DOCUMENT RESUME

ED 430 193 CG 029 284

TITLE	CWLA Standards of Excellence for Services for Adolescent Pregnancy Prevention, Pregnant Adolescents, and Young Parents. Revised Edition.
INSTITUTION	Child Welfare League of America, Inc., Washington, DC.
SPONS AGENCY	Carnegie Corp. of New York, NY.; Mott (C.S.) Foundation, Flint, MI.; National Florence Crittenton Mission Foundation.
ISBN	ISBN-0-87868-689-4
PUB DATE	1998-00-00
NOTE	147p.
AVAILABLE FROM	Child Welfare League of America, 440 First St., NW, 3rd Floor, Washington, DC 20001-2085; Tel: 202-638-2952; Fax: 202-638-4004; Web Site: www.cwla.org
PUB TYPE	Books (010) -- Legal/Legislative/Regulatory Materials (090)
EDRS PRICE	EDRS Price MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Accreditation (Institutions); *Adolescents; Certification; *Early Parenthood; Foster Care; Group Homes; Health Services; *Pregnancy; *Prevention; Social Work; *Standards

ABSTRACT

This revised edition discusses how to use the standards and differentiation of Child Welfare League of America's (CWLA) Standards of Excellence and the Council on Accreditation of Services for Families and Children's Standards for Accreditation. An introduction to the CWLA's standards discusses the following issues relating to teen pregnancy: physiological changes, familial and societal changes, sexual abuse, and poverty. Educational and economic implications of adolescent childbearing, service emphasis and sexuality education issues relating to service delivery, and the role of families and the community in preventing adolescent pregnancy are also examined. Chapter 1 explains the framework for the standards and the subsequent chapters explain specific standards relating to adolescent pregnancy prevention (chapter 2), comprehensive community-based service delivery systems (chapter 3), social work and support services (chapter 4), health care services (chapter 5), and residential services (chapter 6). (Contains 82 references and an index.) (MKA)

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ED 430 193

Child Welfare League of America

STANDARDS OF EXCELLENCE

CWLA Standards of Excellence for Services for Adolescent Pregnancy Prevention, Pregnant Adolescents, and Young Parents

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STANDARDS OF EXCELLENCE FOR SERVICES FOR ADOLESCENT PREGNANCY PREVENTION, PREGNANT ADOLESCENTS, AND YOUNG PARENTS

Child Welfare League of America

CWLA Standards of Excellence for Services for Adolescent Pregnancy Prevention, Pregnant Adolescents, and Young Parents

REVISED EDITION

Child Welfare League of America
Washington, DC

The Child Welfare League of America (CWLA) is a privately supported, nonprofit, membership-based organization committed to preserving, protecting, and promoting the well-being of all children and their families. Believing that children are our most valuable resource, CWLA, through its membership, advocates for high standards, sound public policies, and quality services for children in need and their families.

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CHILD WELFARE LEAGUE OF AMERICA, INC.
440 First Street, NW, Third Floor, Washington, DC 20001-2085
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CURRENT PRINTING (last digit)
10 9 8 7 6 5 4 3 2 1

Cover design by Jennifer Geanakos
Text design by Eve Malakoff-Klein

Printed in the United States of America

ISBN # 0–87868–689–4

The *CWLA Standards of Excellence for Services for Adolescent Pregnancy Prevention, Pregnant Adolescents, and Young Parents* are dedicated to Martha A. Stennis, who served as a member of CWLA's board of directors from 1976; as CWLA vice president from 1986 to 1990; and as president of the National Florence Crittenton Mission Foundation from 1990 until her death in 1997.

The *CWLA Standards of Excellence for Services for Adolescent Pregnancy Prevention, Pregnant Adolescents, and Young Parents* were prepared with the generous support of the Carnegie Corporation, Charles Stewart Mott Foundation, and the National Florence Crittenton Mission Foundation. The views expressed in these standards are those of the Child Welfare League of America and do not necessarily constitute the position of these funding organizations.

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Foreword

Setting standards and improving practice in all child welfare services have been major goals of the Child Welfare League of America (CWLA) since its formation in 1920. With the issuance of this revision, CWLA reaffirms its commitment to establishing standards of excellence that can be used as goals to advance and guide contemporary practice. As we continue to learn more about the essentials for the healthy growth of children, CWLA can help to redefine the responsibility of society to provide for children the conditions and opportunities that encourage their development.

Since the inception of its program of standards development, CWLA has formulated a series of standards based on current knowledge, the developmental needs of children, and tested ways of meeting these needs most effectively. The preparation of standards involves an examination of current practices and the assumptions on which they are based, a survey of the professional literature and standards developed by others, and a study of the most recent experiences of social work and related fields—child development, child care, education, mental health, psychology, medicine, psychiatry, and sociology—as well as other appropriate and pertinent fields such as management, business, technology, communication, and marketing, as they bear on child welfare practice and management.

The final formulation of standards follows an extended discussion of principles and issues by experts in each service area, the drafting of a preliminary statement, and a critical review by CWLA member agencies, representatives of related professions, and other national organizations.

CWLA's preparation of standards involves the wide participation of local, state, provincial, and national agency representatives. Many CWLA member agencies, including state or provincial human service departments as well as voluntary agencies, have contributed the professional time and travel costs of their staff members who developed these standards, reviewed draft statements, and made suggestions for revision. Representatives of national organizations, governmental agencies, sectarian agencies, universities, and professional associations in related fields have taken part in the various committees.

Purpose of CWLA Standards

The CWLA standards are intended to be standards of excellence—goals for the continuing improvement of services for children and their families. They are not the criteria for CWLA membership, although they do represent those practices considered to be most desirable in providing services to children and their families. As goal standards, they reflect what we as a field collectively recognize as the best ways to work with children and their families. They provide us with a vision to which we can aspire. They also are used in the development of the standards of the Council on Accreditation of Services for Families and Children, Inc. (COA).

CWLA standards are directed to all who are concerned with the enhancement of services to children and their families, including parents; public and voluntary child welfare agency governing board members; direct service, supervisory, and administrative staff members; the general public; citizen groups; public officials; courts and judges; legislators; professional groups; organizations serving children and their families; organizations whose functions include the planning and financing of community services; state, county, or provincial agencies entrusted by law with functions relating to the licensing or supervision of organizations serving children and their families; advocacy groups; and federations whose membership requirements involve judgments on the nature of services rendered by their member agencies.

Standards of excellence can stimulate the improvement of ser-

vices only as they question the value of present practices, convey a conviction that change is desirable, offer a philosophic base from which to examine current practice, and provide a vision toward which we can aim. They provide the means to test the premises from which practice develops, and allow the measurement of current services and performance against what is known to be the best possible practice.

Standards are of use in planning, organizing, and administering services; in establishing state, provincial, and local licensing requirements; and in determining requirements for accreditation. They offer content for teaching and training in child welfare and other related fields, in professional schools, in inservice training and staff development programs, and in the orientation of the organization's governing body members, staff members, and volunteers. They can help to explain and justify expenditures and budget requests to fundraising bodies and appropriation committees of legislatures.

Finally, standards can promote an understanding of how a service may more effectively meet the needs of children and their families, what it should be expected to do, and how it can be used. In that way, standards promote increased public interest, understanding, and support for pertinent legislation, improved financing, and the provision of quality services to children and their families.

Review of CWLA Standards

To maintain their visionary quality, CWLA standards are subject to continual review and revision, since knowledge about children, families, communities, human behavior, and the treatment of human needs grows constantly. Developments in management and the social sciences; the continuing evaluation of the effectiveness of current social service practices, policies, and programs; and shifting patterns of social values and social organizations lead to the continued modification of the vision for quality in child welfare practice and management.

On March 26, 1996, a committee met for the first time to begin drafting a revision of CWLA's 1986 *Standards for Services for Pregnant Adolescents and Young Parents.* The 34 executives

that made up the committee represented a broad spectrum of child welfare organizations throughout the United States. Representatives of several other national organizations and other appropriate specialists supplemented the group's expertise.

The draft produced by the committee was circulated to CWLA's five regions for review by the membership. This volume, the result of that process, was approved by the CWLA Board of Directors on June 29, 1997. It henceforth stands as the policy of the Child Welfare League of America for the provision of services to at-risk, pregnant, and parenting adolescents.

JUDITH S. BLOCK
President
Child Welfare League of America, Inc.

DAVID S. LIEDERMAN
Executive Director
Child Welfare League of America, Inc.

Acknowledgments

This revision of CWLA's *Standards of Excellence for Adolescent Pregnancy Prevention, Pregnant Adolescents, and Young Parents* was prepared by an Advisory Committee whose members were selected on the basis of their expertise in this field. They represent affiliates of CWLA member agencies, Florence Crittenton Agencies, national organizations, and affiliated professions concerned with services for at-risk, pregnant adolescents, young parents, and their children.

The Advisory Committee received and discussed suggestions for revisions from 225 member agencies, state and local departments of social services, other organizations, and consultants who were recommended by the committee; additional suggestions made by CWLA staff and board members who reviewed the draft.

Appreciation is expressed to committee chair Laurien Ward, of Youth Services of Philadelphia, for her inspirational leadership, forward thinking, and guidance throughout the process; to CWLA staff Bronwyn Mayden, Director of the Florence Crittenton Division for her expertise on adolescent childbearing issues and devotion to the development of the best possible product, and Eve Malakoff-Klein, Managing Editor, for her thoroughness, attention to detail, and support during the writing of these standards; and to all the members of the committee for their unending devotion to our field of work, and their fierce desire to better the lives of children and their families.

A list of the Advisory Committee members can be found on the next page.

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How to Use CWLA Standards

CWLA standards are designed for quick and easy access to pertinent information.

A two-part format for the standards was approved by CWLA's Board of Directors in 1984. One volume, entitled *CWLA Standards of Excellence for the Management and Governance of Child Welfare Organizations,** presents the generic components of child welfare practice that apply across the field. The components of each specific service are presented in separate volumes and encompass only those service elements applicable to a particular arena of child welfare practice. Each is updated when appropriate.

The contents page of each standard affords a rapid overview of the general and specific subjects covered. For information on a particular practice, the index lists in alphabetical order each subject of interest and its related categories in the text. Each standard is designated by a number. The digit before the decimal point indicates the chapter where the standard can be found; the digits after the decimal point designate its numerical order within the chapter. The first (nonindented) paragraph of each numbered section represents the standard. The rest of each sec-

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* CWLA *Standards of Excellence for the Management and Governance of Child Welfare Organizations* [1996] serves as a replacement for CWLA *Standards for Organization and Administration for All Child Welfare Services* [1984].

tion may be considered as elaboration, explanation, or illustration. The introductory chapter affords a historical background and philosophical overview, and provides perspective for the remainder of the volume.

Various aspects of an issue may be discussed in more than one volume of CWLA's standards and the reader is urged to consult those volumes as appropriate. CWLA's standards series includes volumes addressing services for adoption, child day care, family foster care, health care for children in out-of-home care, in-home aides, independent living, abused and neglected children, residential group care, and family preservation. Information on obtaining these volumes is available from CWLA at the address listed on the copyright page of this volume.

Differentiation of CWLA Standards of Excellence, COA Standards for Accreditation, and State and Provincial Licensing

CWLA Standards of Excellence

The Child Welfare League of America standards of excellence are intended to be used as ideals or goals for practice in the field of child welfare services. They are intended to provide a vision of what is best for children and their families and as such, encourage the continual strengthening of services. CWLA standards carry no implication of control or regulation. Rather, by bringing together the collective experience of the field to bear upon the work of each organization, they provide a valuable tool for both public and nonprofit agencies.

The standards present practices considered to be most desirable in providing services, regardless of the organization's aus-

pices or setting. CWLA's standards program illustrates one way in which a national organization influences practice throughout North America.

CWLA standards of excellence make it possible to compare what exists with what is considered most desirable for children and their families, and to judge the extent to which current performance approximates or deviates from the most desirable practice. The standards have an educational purpose as well, disseminating what is accepted to be the best current thinking and practice in each child welfare service area.

Since CWLA initiated its standards-setting function, it has continued to revise established standards and to develop new ones as new services emerge. Setting standards involves consultation with national experts and direct service practitioners, a comprehensive review of the literature, and the achievement of professional consensus based on knowledge, experience, and research.

COA Standards for Accreditation

Published by the Council on Accreditation of Services for Families and Children, Inc. (COA), the *Standards for Accreditation* constitute a set of requirements for current agency administration, management, and service delivery. They are rigorous but realistic descriptions of practice standards that a competent provider organization should be able to meet. They establish a system based on measurable criteria, and as such, represent a breakthrough in social service accountability. Although the COA standards are based, in part, on CWLA standards, COA is an independent accrediting body for social service organizations.

State and Provincial Licensing

Through the licensing of child-placement agencies, residential group care facilities, family foster homes, and child day care facilities, states and provinces exercise their police power to protect children from risks against which they would have little or no capacity for self-care and protection. Police power, as

defined by Black's Law Dictionary [§1401], is "the exercise of the sovereign right of the government to promote order, safety, health, morals, and the general welfare within constitutional limits and is an attribute of government using the power of the state to enforce laws for the well-being of its citizens." It is the basis of licensing laws. Licensing requirements provide basic protections by the state or province for the well-being of children and their families.

Introduction

Social services for at-risk, pregnant, or parenting adolescents and their children and families must be part of a broad system of support and assistance. Alleviating the problems associated with the untimely bearing and rearing of children by adolescents requires the establishment of a complex framework for service; the linkage of health care, education, counseling, employment, child welfare, and legal resources in the community; and the skills of a variety of professionals. Absent such cooperation and coordination, adolescents and their families are unlikely to realize the full benefits of the services provided to them.

These standards focus on services provided by social workers employed in nonprofit or public organizations serving families and children. We recognize, however, that sound support can be offered by a variety of professionals—psychologists, nurses, social workers, paraprofessionals, and others—in a wide range of settings. The principles and practices described in these standards can be used to guide this broad array of social service providers as well.

Many of the most important services needed by pregnant adolescents, young parents, and their children and families can already be found among the general community services provided for families and children. The distinctive aspects of the problems this population faces, however, warrant the provision of differentiated services for them. Moreover, it should be recognized that special skills are needed and have been developed to help these clients with the problems they face as individuals and as parents. These specific services should be identified and made available to adolescents, regardless of their setting or auspices.

The Nature of the Problem

More than one million females younger than age 20 in the United States become pregnant annually:[1]

- Approximately four in ten girls become pregnant at least once before age 20.[2]
- The teen pregnancy and birth rates in the United States are the highest of any industrialized county—nearly twice as great as those of Great Britain, the next highest nation.[3]
- Fully 76% of births to teenage mothers occur out of wedlock.[4]

The rising rate of adolescent pregnancy has been attributed to several causes: physiological changes in the population; shifts in societal mores and standards of behavior and changes in society's reactions to adolescent sexual activity; alterations in family structures; sexual abuse; limited opportunities for young people; increased media exploitation of sexual behavior; peer influences; and the effects of poverty.

Physiological Changes

Physiological changes are contributing to the increase in pregnancies among adolescents. The onset of menses now occurs about four years earlier than it did one hundred years ago.[5] Scientists predict that the onset of menses will remain steady at age 12 for some time to come.[6] The initiation of sexual activity also occurs at earlier ages. Most youths now begin to have intercourse in their middle or late teens.[7]

Although sexual activity is occurring at earlier ages, young people are reaching other traditional markers of adulthood (i.e., full-time employment, economic independence) at later ages, because more education is needed for today's jobs.[8] As the ages at which young people complete their education and begin full-time employment have risen, and as work has become an ongoing part of most women's lives, marriage and parenthood have tended to occur at older ages, especially for women. The earlier onset of female puberty, coupled with later marriages, has created an increased incidence of out-of-wedlock childbearing.[9]

Adolescents often have difficulty coming to terms with their changing bodies at a time when the influence of their peers is paramount. Sexually active adolescents often emulate their peer role models. Moreover, they often think that sex is not only what everybody else does, but that it is necessary for maintaining an intimate relationship. Contraceptive use can represent an admission of planned sexual activity and can be accompanied by feelings of guilt or immorality. Many adolescents believe that pregnancy only happens to someone else, not to them.

Familial and Societal Changes

Adolescence is a time when young people begin to take added responsibility for their own decisions, many of which often place them in conflict with their parents. An adolescent's need for independence, therefore, is often confused with rebellion and rejection of parental values. Sexual activity can become a means of rebelling. Parents, often uncomfortable with sexual matters, may find it difficult to communicate with their teens.

The presentation to adolescents of mixed messages make it all the more difficult for them to make choices that are in their best interests. Society imposes a different standard on adolescents than it does on adults, then wrongly assumes that teenagers will grasp the difference between behavior that is permissible for adults and that which is acceptable for adolescents.

The quality of the relationship between parents and adolescents is an important factor in the decision by an adolescent to initiate sexual activity. Adolescents who are unable to communicate with their parents, who are the victims of parental abuse or neglect, or who are in conflict with their parents, are at higher risk of involvement in early sexual relationships.

Although families remain the primary caregivers of their children—socially, economically, and physically—as well as the communicator of cultural values and ethnic identities, they are undergoing dramatic change. Many families require two incomes to pay for the basic necessities of food, clothing, and shelter, and must try to find a balance between parenting and paid employment. Divorce is increasingly common, creating a rise in the number of single-parent homes and in the economic pressure on these families. The complex interplay of societal pres-

ure and adolescent development can challenge even the most patient and understanding of parents.

Sexual Abuse

The connection between child sexual abuse and teen pregnancy is well-documented. In one study, 74% of women who had intercourse before age 14 and 60% of those who had sex before age 15 report having had sex involuntarily.[10] In a Chicago study of 445 women who became mothers before age 20, 61% stated that they had at least one unwanted sexual experience.[11] Other studies have also found that much of teens' early sexual activity is involuntary and forced.[12] Sexually abused children are conditioned to appease their abusers, to respond to promises, and to avoid violence.[13] Girls who are being abused may seek attention and protection from older males, only to be victimized again when they are abandoned at pregnancy.

Poverty

Research suggests that children who are poor are more likely than their nonpoor counterparts to become teen parents.[14] The share of families with children headed by a single parent increased from 22% in 1985 to 26% in 1994.[15] Children growing up in single-parent households typically do not have the same economic or human resources available to them as those growing up in two-parent families. These children may face a bleak future unless a change of approach is made toward their vulnerable families.

A large proportion of the country's 24 million teenagers live in families that have difficulty providing such basics as food, clothing, and shelter. Nearly 40% of women and men age 15 to 19 are poor or low-income.[16] Youths of color—Latinos and African Americans—are substantially more likely than Caucasian youths to be economically disadvantaged.[17]

The Consequences of Adolescent Childbearing

Adolescent childbearing has negative health, educational, and economic implications for adolescent parents, their children, and for society as a whole.

Health Implications

When compared to children whose mothers were age 20 or 21 when they had their first child, children born to adolescents are more likely to be premature and 50% more likely to be born at low birthweight (less than five and a half pounds), to have higher health care costs; to be in need of welfare and out-of-home care services; and (for male children) to be involved with the juvenile justice system.[18] Children born to adolescent mothers are twice as likely to be victims of abuse and neglect as those born to mothers 20 or 21 years old. The ratio of foster care placement to reported abuse and neglect is roughly one in four among children born to adolescent mothers and one in five among children born to later childbearers. An estimated 5% of out-of-home care placements might be averted if society could eliminate adolescent childbearing.[19]

Educational Implications

Adolescent mothers have significantly lower levels of educational attainment, higher probabilities of raising their children out of wedlock, and higher rates of dependence on public assistance than do older mothers.[20] Adolescent males also face adverse consequences when they become fathers—they complete less education and earn less income than men who delay fatherhood until age 21.[21]

Economic Implications

The economic costs of adolescent childbearing are high. Researchers estimate that adolescent childbearing costs taxpayers $6.9 billion each year. The increased demand for public-assistance benefits—welfare and food stamps combined—caused by adolescent childbearing costs taxpayers $2.2 billion, while increased medical-care expenses add an additional $1.5 billion. The increased costs of foster care are only slightly less, at $.9 billion.[22]

The cost to taxpayers of adolescent childbearing, when combined with the other disadvantages faced by adolescent mothers, is between $13 billion and $19 billion per year—an amount taxpayers could save if communities successfully delayed adolescent childbearing and addressed these other disadvantages.[23]

The Changing Face of Service Delivery

The need for primary pregnancy prevention services is paramount. Even when such efforts are made, however, some adolescents will continue to be sexually active, and will become pregnant or a parent. In those instances, required supports for both the young parents and their children must be provided. The change in the incidence rates and outcomes of pregnancies among adolescents and our growing understanding of the problem make clear the need for change in the services we provide and in their delivery.

Service Emphasis

Until the last two decades, most of the assistance provided by child welfare agencies to pregnant adolescents focused on pregnancy-related services, such as prenatal medical care, pregnancy resolution, and planning for adoption; often, it was delivered in conjunction with health care facilities. Planning for adoption received particular emphasis due to the sizable proportion of pregnant teenagers then deciding that adoption for the child was in their own and their child's best interest.[24] In more recent years, a much smaller proportion of adolescents who carry to term are choosing adoption. Currently, over 95% of those who carry their pregnancies to term elect to parent their children rather than to place them for adoption.[25] African American teenage women rarely place their infants for adoption.[26]

In many communities, public and nonprofit organizations serving children and families still provide a substantial proportion of services for at-risk, pregnant, and parenting adolescents. These services typically include education programs; contraceptive access; counseling regarding pregnancy resolution; prenatal care; assistance with future living arrangements; income maintenance; education concerning family planning and child development; employment and job training; and child day care. They may be offered and coordinated through referrals, purchase-of-service arrangements, and other agreements. Some organizations are also involved in communitywide activities such as planning or public education to ensure that a comprehensive array of services is available for at-risk, pregnant, and parenting adolescents and that resources are used efficiently.

Child and family service agencies, medical professionals, edu-

cators, psychologists, family planning clinicians, clergy, community planners, politicians, and others are increasingly involved in developing and providing services. Attention is being directed to the needs of adolescent females and males, pregnant adolescents, fathers, and infants and toddlers, as well as their families. The time span for the receipt of services can range from early pregnancy through several years beyond the birth of the baby. Long-term goals for the adolescent such as return to school, preparation for employment, economic self-sufficiency, delay of subsequent pregnancies, and enhanced parent-child interaction are now seen to be as important as good prenatal care and obstetrical outcomes for the mother.

Sexuality Education

Ideally, sex education starts at home, where parents have a role in instructing their children and imparting their values. The parents of children in the child welfare system, however, are not available to meet these needs, including the need for sexuality education. Having assumed the role of parent, the state must ensure that the youths in its care receive adequate information about their sexual development.

State child welfare agencies have placed little emphasis on the prevention of adolescent childbearing for youths in care—relatively few states offer sexuality education for youths in care or training programs for their caregivers or social workers.[27] Yet youths in the child welfare system (family foster care, group homes, and residential care) are at higher risk than their high school counterparts of engaging in early sexual activity and experimenting with alcohol and other drugs, thereby increasing their risk for unintended pregnancy and sexually transmitted diseases. These youths often lack access to sexuality information and, if they are sexually active, to family planning services designed to give them the capacity to delay pregnancy.[28]

Preventing Adolescent Pregnancy

Many youths become parents because they believe that they have limited life options. They may live in economically depressed communities or be surrounded by family and friends who have not had access to social and economic opportunities. There is little reason for these youths to delay sexual intercourse

and to consistently use contraceptives. Strategies that emphasize improved sex education and increased access to contraceptives are of little value to youths in high-risk communities unless they are coupled with strategies to improve the economic, educational, and employment conditions of the community.

Pregnancy prevention strategies must be carefully selected according to the need of the target group. Youths in high-risk life situations (i.e., youths in out-of-home care, incarcerated youths) need programs that build on their strengths and increase their self-esteem; teach them new skills; decrease their educational deficits; foster a belief in themselves and their capacity; provide socialization and strong bonds with caring adults, strong religious faith, and a serious work ethic; and assist them to become healthy and caring adults. Youths who have been sexually abused may need counseling services and therapy. Some youths require strategies to access sexuality information and contraceptive services. Others require reasons to prevent pregnancy (life options model) and the capacity to use such options.

The Role of Families

Whenever possible, the family should remain the primary caregiver for children in our society.

Responsibility for childrearing has many dimensions, from the teaching of basic living skills to the provision of positive role models to the development of moral reasoning and judgment in children. Along with other family members, parents should establish a foundation of values and beliefs to use in helping their children to accept responsibility for making decisions for their own lives and futures.

Many jobs today, as well as those anticipated for tomorrow, require increasingly sophisticated education and technical skills. Parents should help their children understand the demands of our society and prepare them in every way possible to meet those demands. The need to take responsibility for one's own actions must be emphasized.

Pride in one's self and in one's family, ethnic, and culture heritage should be communicated to children by their parents. As social and economic changes in our society cause extended and nuclear families to have less time together, the importance of consistent parent-child communication becomes even greater.

Children need to feel and understand the special nature of childhood so they will strive to build futures and families of their own that convey that message to their children.

The Role of Community Organizations and Institutions

Community agencies and institutions should strive to create structures that reinforce family values; create opportunities for the future; challenge intellectual, physical, and emotional capacities; and assist adolescents in accepting responsibility for their own actions. They should work collaboratively to assure that every adolescent is provided the opportunity to reach his or her maximum potential. The services provided by a broad array of community institutions, including schools, religious organizations, businesses, the media, recreation, and health and social service agencies, can complement parental efforts to guide adolescents and to help them become healthy, productive adults.

Within this collaborative effort, child welfare agencies play a pivotal role: they must encourage all relevant community institutions to act as part of a comprehensive service to help parents prepare adolescents for healthy, productive adulthoods, and they must encourage adolescents to prevent or delay pregnancies until they are prepared to create healthy, productive futures for their children. Child welfare organizations must recognize the diverse complexities of the adolescent pregnancy problem. Although child welfare organizations play a major role, the problem should not be viewed as strictly a child welfare concern. Child welfare organizations must consider the full range of resources available from community agencies that have a mutual concern and responsibility and must be prepared to provide the necessary leadership in the community.

Notes

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1

Framework for the Standards

CWLA's *Standards of Excellence for Services for Adolescent Pregnancy Prevention, Pregnant Adolescents, and Young Parents* are grounded on a set of basic assumptions regarding adolescent pregnancy and parenting, the right to service, and the provision of service. Individuals for whom services are appropriate include the adolescent, male or female, who is at risk of early sexual activity, and therefore at high risk of impregnating or becoming pregnant; the pregnant adolescent and the baby's father, who need help with the problems associated with pregnancy; the young mother and father who need help with the problems of parenthood, or help with planning for their own future and/or the child's well-being; the child born under any of these circumstances; the young biological father of a child born to an adolescent mother, regardless of his legal relationship to the child, and/or his marital status with the mother of the child; the extended families of the young mother and father; and the young married couple.

Basic Assumptions

- Whenever possible, pregnancies and parenthood among adolescents should be prevented or delayed until the adolescents are prepared to create healthy, productive futures for their children.

- A comprehensive array of services should be made available and provided to adolescents at risk of early sexual activity, to those who are sexually active, to those who become pregnant, and to those who choose to raise their children.
- Pregnant adolescents and young parents have the right to receive services without regard to age, race, ethnicity, religion, socioeconomic status, marital status, or plans regarding the resolution of the pregnancy.
- Services should be adapted to the developmental stage of the adolescent (i.e., early, middle, late adolescence) to ensure that interventions are age-appropriate.
- The needs and responsibilities of young fathers* are of equal importance to those of young mothers and should receive full attention in the provision of services.
- Wherever possible and appropriate, help provided by the family should be encouraged, not replicated or jeopardized.

1.1 Delay or prevention of pregnancy

Pregnancies and parenthood among adolescents should be prevented or delayed until the adolescents are prepared to create healthy, productive futures for their children.

Pregnancy, childbearing, and child-rearing in adolescence are generally untimely events, out of sequence with societal expectations and developmental norms. They can have many health, social, and economic consequences for young mothers, fathers, and their children.

Adolescent pregnancy prevention strategies may include programs that help adolescents to delay sexual intercourse, provide access to contraceptives for sexually active teens, motivate adolescents to prevent pregnancy (life options), and give adolescents the capacity to use the options available to them.

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* The term "father" is used throughout this document. It encompasses the male partner who impregnates the female adolescent as well as the young male parent.

1.2 Comprehensive array of services

A comprehensive array of services should be made available and provided to adolescents at risk of early sexual activity, to those who are sexually active, to those who become pregnant, and to those who choose to raise their children.

The array of services for pregnant and parenting teens should include parenting education, child development, infant stimulation, and appropriate discipline for children. The services provided should maximize the developmental potential of the adolescent parents and minimize the consequences to any children born to them.

Service providers should recognize that a large number of pregnant adolescents are the victims of sexual abuse and should be aware that these teens may need intensive therapy.

Services for adolescents and young women who choose to carry their pregnancies to term and raise their children, or who choose adoption as the best plan for their children, must continue well after the birth of the child.

For those who choose to assume child-rearing responsibilities, services should be available until the child enters school, or for as long as the services are needed.

To ensure their optimal growth and development, children born to adolescent mothers should receive an array of services.

Not all pregnant adolescents or young parents need the same services. Comprehensive services should be available but not necessarily provided to all clients. Care should be taken in case planning to set specific goals and objectives with the client and to target services to meet those goals and objectives.

1.3 Right to receive services

Pregnant adolescents and young parents have the right to receive services without regard to age, race, ethnicity, religion, socioeconomic status, marital status, or plans regarding the resolution of the pregnancy.

Clients should not be denied service for any of the above reasons, nor should they be encouraged to alter their status

to obtain services—for example, by leaving a household or seeking one type of resolution for the pregnancy rather than another. The array of services provided should be respectful of, and delivered in the context of, the client's community, cultural, and ethnic background.

Pregnant adolescents and young parents should be fully informed about all possible options—paternity establishment, adoption, assumption of child-rearing responsibilities, termination of pregnancy, family foster care for mother and/or child, legal guardianship by family member, and any other alternatives allowed by federal, state, provincial, and local law.

1.4 Developmental appropriateness of services

Services should be adapted to the developmental stage of the adolescent (i.e., early, middle, late adolescence) to ensure that interventions are age-appropriate.

Attention should be given in case management and service delivery to the different ages and stages of development, and to the special needs of certain groups of pregnant adolescents and young parents—for example, runaways, drug abusers, those pregnant as result of a rape or incest, the developmentally disabled, and the emotionally disturbed.

1.5 Rights and responsibilities of fathers

The needs and responsibilities of young fathers are of equal importance to those of the young mothers and should receive full attention in the provision of services.

Traditionally, pregnant adolescents or young mothers and their children have been the primary clients in the provisions of services.

Regular contact between fathers and their children should be encouraged whenever appropriate, whether or not the parents are married, plan to be married, or are involved in a relationship. Maintaining contact between children and their fathers' families also may be beneficial.

Legal rights and responsibilities of the fathers of children born to adolescent mothers extend beyond the obligation of

financial support. Whenever possible, fathers have the right to establish a relationship with their children and to influence the decisions that affect their welfare. They also should share responsibility with the young mother and others for their children's health and physical care, education, and personal/social/ethnic/cultural development and support.

1.6 Involvement of the adolescent's family

Wherever possible and appropriate, help provided by the family should be encouraged, not replicated or jeopardized.

The families of pregnant adolescents' and young parents' often are their main source of financial as well as emotional support.

Involvement of the adolescent's family, including grandparents and other extended family members, in any service program, is in most situations desirable in terms of enhancing the impact of services. It should not be used, however, as the prerequisite for receiving services, nor should it breach the client's right to confidentiality.

Goals for Service

1.7 Goals for the high-risk adolescent

The goals of service for high-risk adolescents, both male and female, are to help those individuals obtain the information, skills, and confidence they need to avoid early sexual activity, and to present to them realistic alternatives to engaging in sexual activity so as to prevent or delay adolescent pregnancies and to maximize their personal development.

1.8 Goals for the pregnant adolescent

The goals of service for the pregnant adolescent are to develop a plan that will inform her of the options regarding pregnancy resolution; to counsel her in making a decision on pregnancy resolution; to assure that she receives quality medical care in relation to the pregnancy as well as other medical needs; to continue her education; to facilitate her healthy adolescent and

adult development; to encourage heightened self-esteem and self-sufficiency; to support overall family functioning and positive peer relationships; and to assist her in maximizing her personal functioning.

1.9 Goals for the expectant father

The goals of service for the expectant father are to inform him of the options regarding pregnancy resolution and, if possible, involve him in the decision-making process with the pregnant adolescent; to encourage his participation in childbirth education classes; to inform him of his legal rights and responsibility as a father; to enhance his ability to care for and stimulate his child if the decision to carry the pregnancy to term and to parent is the option selected; to promote economic self-sufficiency; to encourage him to complete his education; to encourage participation in postpartum services; to encourage the use of family planning to prevent repeat pregnancies; to support family functioning and positive peer relationships; to encourage heightened self-esteem; and to assist him in maximizing his personal functioning.

1.10 Goals for the young mother

The goals of service for the young mother are to promote excellent physical health; to enhance optimal mother-child interaction through participation in parenting education classes; to heighten self-esteem; to promote economic self-sufficiency; to encourage her to complete her education; to encourage participation in postpartum services; to facilitate family planning to prevent repeat pregnancies; to support family functioning and positive peer relationships; and to assist her in maximizing her personal functioning.

1.11 Goals for the children of young parents

The goals of service for the children born to young parents are to promote the healthy well-being of the children; to support the parent in assuming the responsibilities of child rearing; to assist the parents to become aware of the needs of their children and the support services that are available in the commu-

nity; and to assure that the children receive appropriate, quality, health and child care services.

1.12 Goals for the social worker

The goals for the health and social workers are to increase their knowledge of adolescence and adolescent development, the community and its resources, and sexuality issues; to improve their ability to communicate effectively and comfortably their knowledge of sexuality issues; to improve their ability, through ongoing training opportunities, to assess the young parents' parenting skills; and to work with different populations in a culturally competent manner.

1.13 Goals for the community

Each community should seek to reduce the incidence of adolescent pregnancy.

> The National Campaign to Prevent Teen Pregnancy recommends the reduction of the pregnancy rate among teenage girls age 15 to 19 from the current level of about 115 pregnancies per 1,000 to 75 per 1,000 by the year 2005, which would represent about a one-third reduction in the rate.[1]
>
> Effectively combating adolescent pregnancy will involve the mobilization of an extraordinarily broad and diverse range of resources: families; religious groups; media; community and neighborhood groups, including civic clubs, fraternities and sororities, PTAs, and neighborhood improvement associations; the business community and labor; and public and private agencies in the areas of health, mental health, education, social services, income maintenance, and employment and training.

Notes

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2

Adolescent Pregnancy Prevention

Nearly every discussion of teen pregnancy—its causes and its consequences—arrives at the conclusion that the problem is complex and that there are no simple solutions. Individual responsibility and social problems are intertwined and both must be addressed with equal vigor and determination: Is teen pregnancy the result of an individual lack of responsibility, maturity, knowledge, and self-esteem, or is it the end product of pervasive social problems associated with race and economic class, such as lack of quality education and employment opportunities for youths in high-risk communities?

Teen parenting is costly in both human and fiscal terms. Adolescent childbearing places young mothers, fathers, and their children at great disadvantage and creates health, economic, and social and emotional problems for the teen parents, their children, and their families.

Pregnant adolescents are more likely to suffer from severe anemia, toxemia, labor and delivery complications, and high morbidity rates. Because they are less likely than older women to obtain early prenatal care and follow sound nutritional practices, they are more likely to produce premature and low-birthweight babies, who in turn have higher than average incidences of mortality, congenital birth defects, mental retardation, and serious childhood diseases.

Adolescent parents and their children are more likely to be dependent upon welfare supports for financial assistance

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for prolonged periods. Parenting can have a negative impact on an adolescent's educational attainment and can limit career opportunities. Adolescent parents have the highest probability of encountering unemployment and inadequate income, particularly if either or both parents experience a truncated education; the latter can hamper them and their children for a lifetime.

Significant social and emotional consequences of adolescent parenting include high divorce rates, marital instability, increased incidence of child abuse, and heightened family tensions.

The goal of pregnancy prevention programs is to reduce dramatically the incidence and rate of teen pregnancy. Program objectives should include

- promoting abstention from sexual intercourse until the teen is psychologically, emotionally, economically, and physically ready;
- encouraging a decrease in the adolescent's frequency of sexual intercourse or in the number of his or her sexual partners';
- encouraging the use of effective contraceptive methods;
- building the adolescent's self-esteem, refusal skills, and decision-making skills; and
- providing programs that meet the social, emotional, educational, and medical needs of young people.

2.1 Adolescent pregnancy prevention programs for youths in out-of-home care

The child welfare organization should have in place, develop, or provide access to age- and developmentally appropriate, comprehensive, pregnancy prevention programs for youths in out-of-home care; should develop programs and policies that support the provision of sexuality education, family planning services, and life skills training to those adolescents; and should advocate for the healthy development of youths in out-of-home care.

Youths in the child welfare system often have complex sexual histories, including early sexual initiation, multiple

sexual partners, and high rates of sexually transmitted diseases. Many are the victims of sexual abuse or were neglected or otherwise victimized in their early years. Several studies have documented the lack of knowledge of youths in out-of-home care of appropriate methods to protect against sexually transmitted infections.[1]

Adolescent pregnancy prevention programs can help youths to make responsible decisions concerning their own sexuality and health by making available or providing access to sexuality education and family planning. They should teach resistance skills; make available family counseling (including parent-child communication concerning values); offer information on or access to contraceptives for parents as well as children; provide role models and mentors; provide opportunities for job exploration and educational attainment; encourage the exploration of religion and its values; and foster physical fitness and social development.

As child welfare agencies plan and implement their adolescent pregnancy prevention programs, they should exercise care to ensure that their services are age and experience appropriate.

For young teens, who may not be sexually active, the message should emphasize abstinence and the delaying of sexual intercourse, and should provide the skills and information the youth needs to avoid early childbearing.

For older teens, the message should emphasize access to health care services and family planning methods, provide information on date rape, and recognize that the adolescent may have been sexually abused.

Both young and older adolescents should be provided with information to strengthen their resistance skills.

2.2 Identifying youths at risk for early sexual activity and other high-risk behaviors

Assessment of a youth's risk for premature sexual activity and other high-risk behaviors should take place in concert with that youth's health assessment as he or she comes into care, or within 30 days of entry into care, and should be repeated at various intervals while the youth is in care. At a minimum, the assess-

ment should cover social and emotional development, physical development, health habits, family history, family functioning, and school performance.

Within 30 days of an adolescent's entry into care, the child welfare social worker should assess the youth's sexual development to ascertain his or her risk for early sexual activity and the need for a referral for services. Both the worker and the organization as a whole should know the indicators that identify youths as at risk for early sexual activity and other high-risk behaviors, and for early childbearing. Behaviors and characteristics that place adolescents at high risk include

- early acting out or involvement in delinquent activities;
- easily influenced by peers;
- lack of parenting skills and social resources;
- one grade behind in school, high absentee rates, poor reading skills, and low grades;
- sibling of a teen parent;
- residence in an impoverished community;
- history of sexual abuse; and
- born to a teen parent who remains single.

The child welfare worker assessing the adolescent's level of risk for early sexual activity should also consider the adolescent's age at the onset of puberty and other developmental milestones; current age; race; socioeconomic status; degree of religious observance; academic achievement; dating behaviors; family characteristics (i.e., family background, parental support and control); media and societal values; and peer group influences.

The effects of discrimination and poverty may place some youths at increased risk of early sexual activity.

2.3 Inclusion of males in adolescent pregnancy prevention programming

The organization should recognize the need and strive to include adolescent males in its adolescent pregnancy prevention programs, and should provide educational opportunities, skills

training, employment assistance, abstinence, family life education, and family planning services to members of these clients.

Early sexual activity, teen pregnancy, and teen parenthood are not problems peculiar to adolescent females. A definition of the at-risk teen population is incomplete if it fails to include the males, whose responsibilities, needs, anxieties, and fears are as much a part of the problem—and eventual solution—as those of their female counterparts.

- Although data on teenage fatherhood are scant, it is known that adolescent males are one-third as likely as their female peers to become parents.[2]
- Adolescent fathers experience economic and educational consequences similar to those of adolescent mothers. They complete school less frequently and earn less money than young men who delay fatherhood until age 21.[3]
- Research has shown that young males tend to influence their female partners about when to become sexually active and whether to use contraceptives during sexual intercourse.[4]
- Teen males frequently lack adequate knowledge of reproductive physiology. This lack of knowledge often extends to contraceptive use as well.

Strategies that may prove useful in enhancing a sense of sexual responsibility in males include the provision of comprehensive sexuality education and family planning services, and the enhancement of life options by providing the adolescent males with educational opportunities, skills training, and employment.

The organization should not overlook the role of older men in pregnancies among adolescents. On average, fathers of children born to teen mothers are 2.5 years older than the mothers; in one-fifth of the cases, they are at least six years older.[5]

2.4 Family life education programs

The organization should develop and implement comprehensive family life education programs that address the biological,

sociocultural, psychological, and spiritual dimensions of sexuality from a cognitive (facts, dates, and information), affective (feelings, values, and attitudes), and behavioral (skills) perspective.

Family life education imparts knowledge or influences and explores attitudes about human development, relationships, personal skills, sexual behavior, sexual health, sexuality, and culture. As of 1996, 37 states required sexuality education in the public schools.[6] The program content, however, differs in each jurisdiction, implementation is usually inadequate, and program quality varies.

- Some school districts require the inclusion of such topics as interpersonal relationships, physiological and personality changes, advanced physiology, and the psychology of human sexual development; others include only anatomy and physiology.
- Programs are often minimal in content, with inconsistencies in teacher training and a low priority assigned to the course; in many schools, family life is a noncredit course.

Family life and human development programs do not encourage children to become sexually active. Although family life education has not been found to directly impact the use of contraceptives, it has been shown to positively affect

- student communication and decision-making skills;
- parent-child communication, resulting in a greater sense of comfort in discussing sexual issues within the family; and
- knowledge, particularly for younger adolescents, on topics of birth control, sexually transmitted diseases, and the probability of becoming pregnant.

Family life education programs seek to reach adolescents early with information on sexuality, to increase their awareness of pressures to become sexually active, to reinforce their ability to say no, and to build their assertiveness skills.

While a decrease in adolescent sexual activity as a result of participation in family life education would be welcomed, knowledge alone cannot be expected to alter teen behavior. Comprehensive family life programs may increase the rein-

forcement of family values, responsible behavior, and self-control with regard to sexual activity.

Those programs that show modest behavioral effects share several important characteristics. These characteristics are similar to those of programs that are effective at reducing substance abuse. The programs should

- focus clearly on reducing one or more behaviors that lead to unintended pregnancy or HIV/STD infection;
- incorporate behavioral goals, teaching methods, and materials that are appropriate to the age, sexual experience, and culture of the students;
- last long enough to allow participants to complete important activities;
- provide basic, accurate information about the risks of sexual activity, including sexually transmitted diseases, unprotected intercourse, and methods of avoiding unprotected intercourse;
- employ a variety of teaching methods designed to involve the participants and have them personalize the information;
- include activities that address social pressures related to sex;
- provide models of and practice in communication, negotiation, and refusal skills; and
- select teachers or peers who believe in the program and then provide them with training, including practice sessions.

Organizational policies that support the provision of sexuality education for youths in care should include the statutory and regulatory basis for the organization's programs and operations.

All appropriate staff should receive copies of the organizational policies regarding sexuality education.

2.5 Assertiveness and decision-making training

The organization should provide opportunities for youths to participate in program planning and implementation as a means

to help hone their decision-making skills, their assertiveness, and their self-worth.

Youths in the child welfare system are in particular need of training in assertiveness and decision-making. Many of these youths enter the system because of abuse and/or neglect and are vulnerable to feelings of inadequacy, victimization, and low self-esteem. Young women with a history of sexual abuse are often "conditioned" by its long-term negative effects on self-esteem and self-concept, and exhibit a lack of responsible sexual decision-making (a leading precursor of adolescent childbearing).

Assertiveness and decision-making training can teach problem-solving skills, decision-making skills, and interpersonal communication skills, and can help young people to employ their knowledge about sexual abstinence, reproduction, and contraception as they develop and implement their personal approaches to sexual activity. Modeling, role playing, rehearsal, and other techniques should be used in teaching these skills. Youths should also be given opportunities to serve as peer health educators, counselors, or to participate on teen panels.

Adolescent pregnancy prevention programs must be broadened beyond sexuality education, contraceptive access, and improved life options, and must confront issues of date rape, child abuse and neglect, gender, and self-worth. The organization should strive to empower youths and to enhance their self-worth by providing opportunities for them to participate in programs that promote sexual equality and nontraditional employment opportunities.

2.6 Mentoring and role model programs

The organization should recruit and train individuals to act as mentors and role models for youths in its adolescent pregnancy prevention programs.

Role model and mentoring programs use trained peer counselors, mentors, and adult community volunteers to provide individual support, counseling, and tutoring for teenagers. With the assistance of mentors and role models, teens can learn to recognize and adopt positive behaviors.

Traditionally, mentoring does not stand alone as a program but is a component of a comprehensive pregnancy prevention effort. Role models and mentors provide important resources for youths in the child welfare system. Youths who participate in mentoring programs begin to see what they can become and to develop a positive view of the future.

2.7 Increasing access to family planning

The organization should either offer family planning services or should provide information and assistance to youths in accessing such services, should work with local jurisdictions to ensure that youths in care receive priority for family planning services, and should advocate for sufficient funding to local providers for family planning services.

Most child welfare organizations do not provide family planning services on site. Organizations that do not have family planning services on site should provide youths with a referral to and the location of the nearest family planning provider, assistance in making an appointment, transportation to the appointment, and follow-up to ensure compliance with the contraceptive method.

Family planning services may be offered in a variety of locations, including hospital outpatient departments, local health departments, physician offices, school-based clinics and freestanding facilities. Regardless of location or auspice, family planning services should be provided free of charge to adolescents.

The child welfare worker providing referrals to family planning services should be familiar with local family planning resources and should be knowledgeable about contraceptive methods and the effectiveness of each method in preventing pregnancy or sexually transmitted diseases.

One of the most effective ways to prevent teen pregnancy is to provide access to comprehensive reproductive health services (i.e., a program of education, medical services, and counseling). Such comprehensive programs provide services ranging from the advocacy of abstinence from sexual activity to the provision of appropriate medical services for sexually active adolescents.

Comprehensive reproductive health care services* should include a variety of health, education, and counseling services related to birth control, including contraceptive services, pregnancy testing and counseling, and information and referral. Services should promote abstinence from sexual activity as well as advocate for and provide appropriate medical services for sexually active teens.

Comprehensive reproductive health care services are based upon three component services:

- Education, including information on responsible and informed decision making about one's own or one's child's reproductive health; topics related to sexual activity, childbearing and parenting; pregnancy prevention options; the prevention of sexually transmitted diseases; and communication skills.
- Core medical services, available upon request, including appropriate physical exams and diagnostic assessment, with referral as indicated.
- Counseling, including information on responsible decision making; pregnancy prevention options; reproductive health; sexual abuse; sexually transmitted infections; communication with parents, foster parents, and significant others; and interpersonal relationship with peers.

While research[7] demonstrates the effectiveness of family planning services in reducing teen pregnancy, family planning alone is not the key—adolescents need educational and counseling programs as well. These programs must be age and developmentally appropriate.

One major problem is related to the early physical development of teens, especially females, whose cognitive and emotional development may not keep pace with their physical development. The unevenness in growth and development makes a compelling case for the inclusion of strong educational and counseling components.

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* See Chapter 5 of this volume for additional standards regarding the provision of health care services to at risk, pregnant, or parenting adolescents.

Youths in out-of-home care may have educational deficits that may only increase once placed in care away from family and friends.

2.8 Programs that enhance life options

The organization should include in its adolescent pregnancy prevention efforts, or provide access to, programs to enhance life options, including tutoring to improve school performance, career awareness, and employment training.

Adolescents must be *motivated* to prevent pregnancy or the provision of sexuality education and contraceptive services will not be effective. Programs that provide sexuality education and increase access to contraception are only two of the components of a successful adolescent pregnancy prevention effort. These components provide adolescents with the information to delay or prevent pregnancy and the capacity to prevent pregnancy. Programs that enhance young people's sense of their future, their sense of self-worth, their understanding of the value of education, and their awareness of work and career options serve to enhance their life options as well.

Low academic achievement and teen pregnancy are directly linked. Teen pregnancy rates are highest among students who perform poorly in school. Poor school performance erodes an individual's healthy self-concept and his or her self-esteem—the first line of defense against unwise, irresponsible sexual behavior. In addition, school achievement is the key to the employment opportunities and life options that can motivate teens to avoid the risks and adverse consequences of pregnancy. Programs that provide tutoring, stress school-to-work readiness, and promote school attendance can improve school performance.

Rampant, chronic unemployment and poor job prospects among high-risk youths are major proximate causes of teen pregnancy and are also adverse consequences of teen parenting. At-risk teens should be provided with career awareness and job readiness training, and should be provided with summer and part-time jobs.

Notes

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3

Comprehensive Community-Based Service Delivery Systems

Too often, service systems for at-risk or pregnant adolescents, young parents, and their families are cumbersome and confusing, and are complicated by the diversity of services generally required by this population. Instead of a unified system, adolescents are presented with a complex group of separate services that have limited working relationships with or accountability to one another. Exacerbating the situation, the services cross several disciplines—medicine, social work, religion, mental health, and others—in both the public and private sector.

At-risk or pregnant adolescents, young parents, and their families can best benefit from a wide range of community-based prevention and support services if those services are part of a comprehensive.coordinated service system. Such a system of services can meet the many needs of this population by providing the full spectrum of health, education, employment, and social services that will promote their growth and development.

At-risk, pregnant, and parenting teenagers need many types of assistance. Sometimes that assistance will come from family and friends; in many instances, however, such help is unavailable. Many teenagers who become parents come from families with severe problems such as alcoholism, spousal abuse, sexual

abuse, and chronic unemployment. For teens who lack the support and guidance of their families, outside services and supports are essential.

> The National Center for Health Statistics reports that two-thirds of the children born to teenage mothers are fathered by men age 20 or older.[1] Although teenage mothers account for 12% of all United States mothers, only 5% of fathers are teenagers. In addition, many teen mothers are the victims of early sexual abuse.[2] Surveys of teen mothers reveal that two-thirds have histories of sexual and physical abuse.

Establishment and maintenance of a coordinated community-based service delivery system for at-risk, pregnant, and parenting adolescents is often blocked by a scarcity of resources. Few communities are able to offer the full array of services necessary, and developing these services requires both a long-term commitment by community agencies and an investment of resources by policymakers and public officials. Service providers who are willing to commit themselves to influencing public policy to increase the resources available to meet their clients' needs are likely to be the most effective in the long term.

Even if the complete continuum of services is unavailable, a community-based system that links existing services together can be more effective and less costly than a system in which services are provided without coordination. This chapter describes the basic elements of a coordinated system of service delivery for at-risk and pregnant adolescents, young parents, their children, and their families. Although systems will differ markedly from community to community, depending upon the service system priorities and resources of each, this description of the basic elements and structure of a service system can guide child welfare agencies and communities that wish to improve their service delivery. In addition, this chapter suggests a leadership role for the child welfare agency in developing such a coordinated service system.

3.1 Components of a service system for pregnant adolescents, young parents, and their children

At a minimum, a coordinated service system for at-risk or pregnant adolescents, young parents, and their children should in-

clude case management; education, including pregnancy prevention and sexuality education (see Chapter 2); health care (see Chapter 5); social services, including parenting support and education; employment and training; and child day care services, as well as financial assistance. Adolescent fathers should also be served by the coordinated services system.

Case Management

3.2 Goal for case management services

Case management services should be provided to coordinate the delivery of services, to achieve effective management of and accountability for services, to eliminate gaps in service availability, and to ensure that services are not only available to at-risk, pregnant, and parenting teens, but that they are sensitive to the needs of the target population as well. Case management services should be provided to male as well as female clients.

The effective use of services demands that the pregnant or parenting adolescents be reliable and keep appointments, plan ahead, arrange for transportation and child care, and assess their own needs and the needs of their children to determine an appropriate course of action. Unfortunately, a significant proportion of teens are ill-equipped to meet these demands. Although services exist and are delivered in such areas as health, education, social services, income maintenance, and employment and training, systematic outreach, coordination, linkage, and comprehensiveness is lacking in the delivery of these services to at-risk, pregnant and/or parenting teens. Coordination and linkage of such services are essential to the effectiveness of any attack upon the teen pregnancy and parenting problem.

Case management systems should be implemented for teens at high risk of pregnancy and parenting, not just for those already pregnant or parenting. The child welfare organization should strive to identify this at-risk population, to offer its members preventive services, and to provide a case management service that will include a service plan to be monitored in the same manner as its system for pregnant and parenting teens.

3.3 Provision of case management services

The child welfare organization should take responsibility for providing case management services because of its unique overview of individual and family needs.

Many organizations including health care facilities, schools, and social services agencies, provide case management services as part of their comprehensive system of services. Whichever organization provides the primary service should be prepared to exercise a leadership role in the service system. Case management provider organizations must work on a systemwide, as well an individual basis to ensure that appropriate and necessary resources are available to clients.

3.4 Components of case management

The organization's case management system should be capable of identifying members of the target population, offering appropriate services to them, and providing case management services, and should be backed by an adequate, responsive network of services.

1. *Identification of the Target Population*

   Local health departments, clinics, and school-based health centers that provide pregnancy tests should provide counseling to all teenagers, whether or not those teens have a positive pregnancy test. At-risk teens who have a negative pregnancy test should be referred for appropriate community-based pregnancy prevention services. A system should be devised whereby, after the birth of a child to an adolescent, the local child welfare organization is notified and the young parents are offered services.

2. *Offer of Appropriate Services*

   A coordinated effort should be made to offer services to at-risk, pregnant, and parenting teens, and to systematically lead them to both public and private agencies providing the appropriate specialized services.

3. *Provision of Case Management Service*

   Case management can be provided as a separate service, or in close association with other services, and should include

- a full assessment of an individual's or family's strengths, and needs, including specialized diagnostic services as necessary;
- the development of a plan of service;
- implementation of the plan by arranging for the delivery of a variety of public and private services;
- follow-up and assessment of the effectiveness of services, with a change in the service plan as appropriate; and
- advocacy on behalf of the individual or family, to see that the services or benefits are received.

Educational Services

The fundamental need for a good education in modern society cannot be overstated.

3.5 Goal for educational services

Child welfare organizations should collaborate with educators and other community agencies to ensure that at-risk, pregnant, or parenting adolescents complete their high school education or obtain their GED, and should encourage the achievement of a higher level of education wherever possible. Child welfare organizations, in concert with the schools, should set numerical targets for achieving their education goals (i.e., 100% of teen parents will graduate from high school or obtain a GED).

Pregnant and parenting teenagers account for a growing proportion of the population served by public schools and child welfare organizations. An estimated four in ten girls will become pregnant at least once before reaching age 20.[3]

Pregnancy and parenting present major challenges to full-time school attendance. Pregnant adolescents drop out of school at staggering rates. Teen mothers who return to school often find it difficult to complete their education.

3.6 Pregnancy prevention education

The child welfare organization should encourage the education system to play a major role in preventing adolescent pregnancy

and to provide a comprehensive health education curriculum that teaches students about the biological, sociocultural, psychological, and spiritual dimensions of sexuality; health care services through school-based health centers; and guidance and counseling to assist youths in making healthy decisions.

3.7 Coordination of educational services

The child welfare organization should consult with appropriate school personnel to determine the need for special arrangements or services for at-risk, pregnant, or parenting teens; to work out appropriate educational goals; and to assure that arrangements for achieving those goals are made.

Cooperation with the school makes it possible for those working with school-age parents to exchange experiences, to better understand the adolescent's situation, and to involve the adolescent parent in using the most appropriate educational services.

3.8 Components of educational services

The child welfare organization should consult with the school staff (principle, teachers, school nurse, guidance counselors, and school social worker) when it is first known that a teen is pregnant, and should establish a plan for that teen's education. The child welfare organization should advocate to ensure that pregnant and parenting adolescents have the same access to educational programs as is available to any other adolescent, at the same time recognizing that some adolescent parents will do better in alternative or specialized programs.

Building a continuum of educational services that will serve pregnant adolescent and young parents adequately requires the involvement of local school systems, including the general education program, the vocational education program, and in some communities, the special education program. In addition, alternative school programs that are administered separately from the standard educational program may need to be involved. The plan established by the child welfare organization in consultation with the school should include provisions for monitoring school attendance, child

day care, transportation, employment and training, and a educational and life options, and should offer:

- standard educational programs;
- GED (General Equivalency Diploma) programs, or other high school;
- remedial or special education;
- special alternative school programs structured in relation to the need of adolescent mothers and fathers;
- vocational education, training, and rehabilitation programs;
- exposure to various career paths to encourage and assist the adolescent parent in the transition to the world of work;
- special and home tutoring programs, particularly for the weeks immediately following the birth of the baby;
- post-high school education opportunities;
- preparation in independent living;
- flexibility in school scheduling;
- counseling and monitoring by school personnel to ensure school attendance;
- coordination with community service providers;
- instruction in prenatal health and parenting;
- outreach to pregnant and parenting dropouts;
- teacher education programs designed to eliminate teacher bias;
- school-based child day care programs;
- school-sponsored peer support programs that offer teen parents counseling, emotional support, and tutoring; and
- financial aid for teen parents to go to college and vocational schools.

Health Care Services

Pregnant and parenting adolescents and their children require a broad range of health care services tailored to their

special needs and circumstances. Such a comprehensive health care system must extend beyond school-based programs to serve adolescents who are no longer in school and to act as a backup for school-based programs.*

3.9 Goal for health care services

The child welfare organization should assure that pregnant teenagers and young parents have access to and can obtain health care services, including medical, educational, and psychological services; an enriched and comprehensive array of maternity services to minimize individual risks for poor pregnancy outcomes; and preventive care.

Many pregnant teenagers and parenting adolescents have inadequate health insurance. As a result, they are often unable to obtain preventive health care for themselves or their children, and are forced to wait until a health problem grows into a crisis before seeking a doctor.

The child welfare organization should provide assistance with health insurance applications and paperwork, arrange for health care appointments, and teach young parents how to access the health care system.

3.10 Coordination of health care services

The establishment of adequate provisions for safeguarding and promoting the health care needs of pregnant adolescents, young parents, and their children should be a shared responsibility between the child welfare organization and the health care service provider. The child welfare organization should consult with the health care service provider to ensure that adequate health care services are available for pregnant and parenting adolescents and that all pregnant adolescents receive appropriate prenatal care.

Pregnant and parenting adolescents have all the regular health care needs of their peers. In addition, when compared to older mothers, adolescent mothers show increased

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* See Chapter 5 of this volume for additional standards regarding the provision of health care services to at-risk, pregnant, or parenting adolescents.

incidences of severe anemia, toxemia, labor and delivery complications, and morbidity. Pregnant adolescents are less likely than older women to obtain early and continuous prenatal care and are more likely to suffer vitamin deficiencies. Subsequently, they are at increased risk of delivering premature and low-birthweight babies.[4]

3.11 Components of health care services

A community system of health care services for at-risk, pregnant, and parenting adolescents and their children should provide (1) ongoing primary care for the adolescent mother, father, and their child; (2) pregnancy testing and maternity counseling; (3) primary and preventive health care services, including pap smears, breast examinations, and prenatal and postnatal care; (4) comprehensive reproductive health care services; (5) adoption counseling and referral services; (6) nutrition information and counseling; (7) screening for and treatment of venereal disease or referral to appropriate treatment services when needed; (8) provisions of and/or referral to appropriate pediatric care; (9) educational services related to family life and problems associated with adolescent premarital sexual relations; (10) referral to licensed residential care or maternity home services when needed; (11) mental health care; (12) counseling for the immediate and extended family members of the adolescent regarding parenting education (including appropriate relationships to discourage sexual relations among minors, and parenting and parenting education); and (13) home visiting services.

Social Services

Many teens who experience unplanned pregnancies report having feelings of low self-esteem and a lack of future aspirations. Conversely, teens who are eagerly anticipating their adult lives appear to be less likely to be involved in unintended pregnancies. Social service programs that help teens to develop positive self-esteem through skill-building activities, personal ambition, and options for the future can help prevent early pregnancy. There are two major types of social service providers.

- Governmental programs provide services necessary for family survival through federal, state, and local funding (i.e., Temporary Assistance for Needy Families, Medical Assistance, Food Stamps). Although some do not consider these to be preventive programs, the basic supports of food, income, and health care are essential to the development of healthy children and healthy lifestyles.
- Other providers, typically nonprofit agencies, offer life options programs. These programs provide at-risk youths with housing, food, clothing, broadened life experiences, and increased opportunities through educational, employment and training, and recreational opportunities.

3.12 Goal for social services

An offer of social services should be made to every at-risk, pregnant, and parenting teenager under 16 years of age. The social worker should assess the strengths of the family, assist in the development of a plan of service, and monitor the plan of service.

The child welfare organization should assist at-risk teens to refrain from early sexual activity, to prevent or delay adolescent pregnancy, and to maximize personal development.

The child welfare organization should assist at-risk teens to obtain sexuality education, access contraceptive services if they are sexually active, and increase their life options. If the organization does not directly provide a needed service, it should provide a referral and help the client establish a link to that service.

Youths placed in out-of-home care because of abuse, neglect, or abandonment are particularly vulnerable to too early childbearing. With higher than average rates of sexual activity, multiple sex partners, high usage of alcohol and other drugs, less access to contraceptives, and little parenting support and guidance, youths in care have higher than average rates of STDs, including HIV.

Youths with a history of sexual abuse, rape, or prostitution should be provided with counseling. Parents and other caregivers should receive training to assist these youths in enhancing their coping skills and, if the youths are sexually

active, in practicing safer sex or abstaining from sex. The caregivers should also receive sexuality education training that includes anatomy, relationship skills, skill building activities, resistance techniques, and tips on talking to youths about sex.

The child welfare organization should have written policies that support the provision of sexuality education for youths in care. Such policies should include the provision of family planning services for sexually active youths.

Family planning services should include a variety of health, educational, and counseling services; pregnancy testing and counseling; and information and referral services. Mentoring and peer counseling services should also be available.

3.13 Coordination of social services

The child welfare organization should encourage and help coordinate the involvement of a variety of community agencies in providing counseling to prevent adolescent pregnancy and in providing social services to at-risk, pregnant, and parenting adolescents, including, but not limited to, public and nonprofit child welfare organizations; family service agencies; boys and girls clubs; schools; community and volunteer organizations; religious organizations; and youth-serving organizations.

Because of the wide range of agencies involved in this type of service, coordinated planning is particularly important.

3.14 Components of social services

The range of social services is broad; at a minimum, however, the child welfare organization should offer or facilitate access to counseling; family mediation; homemaker and parent aide services; family supports; parenting education; adoption information; referrals for housing, child day care, education, and recreation services; and independent living skills.

At-risk, pregnant, or parenting adolescents may need some or all of the following services:

- counseling services to assist them with decisions about unintended pregnancies, beginning immedi-

ately after a positive pregnancy test, as well as counseling after the birth of the child;

- family mediation services to improve interaction among family members, between the adolescent mother and father, or among family members and the young parents;
- homemaker and parent aide services that provide guidance and role modeling;
- family support services, including income supplemental assistance, medical assistance, food stamps, and WIC (Women's Infant Program)
- parenting education and support programs;
- adoption services that provide information and education about adoption procedures;
- referrals for affordable housing alternatives;
- referrals for quality, affordable child day care;
- referrals for educational services;
- referrals for recreational services, which can provide opportunities for pregnant or parenting adolescents to develop self-esteem and discipline as well as decision-making skills, and can expose them to role models and professions that may be instrumental in planning their future; and
- independent living skills to help them prepare for adulthood.

3.15 Parenting support and education

Parenting support and education programs should be made available to help all adolescent parents develop the knowledge and skills necessary for child-rearing. Parenting education should be a mandated service for youths in the child welfare system.

> Children of adolescent mothers are far more likely to be physically abused, abandoned, or neglected than are children of older parents.[5]

> Because they have often been deprived of parental guidance and support, youths in care need knowledge of the

age-appropriate growth and developmental needs of children and the ability to apply that knowledge to their children's behavior in a manner consistent with societal values and expectations.

Generally, parenting education for adolescents is most effective when it is provided outside of the classroom through less formal counseling or role modeling, and in association with other activities such as child care discussion groups or peer counseling activities. For this reason, parenting support and education services are often provided in association with other direct service activities.

Peer counseling and support services can help adolescents increase their self-esteem, assume more responsibility for their actions, and develop a sense of control, choice, and empowerment in relation to their own behavior. The interaction of adolescents who have successfully coped with issues of sexuality, parenting, pregnancy, or child-rearing, with those adolescents who are struggling with the same issues can benefit both groups.

Employment and Training Services

Although in past years it might have been assumed that adolescent mothers would stay at home with their children and not work, it is now recognized that the most important assistance that can be provided to an adolescent mother or father is a marketable skill. In this, adolescent parents are similar to other adolescents—the best service goal for this population is to prepare them for long-term independence.

3.16 Goal for employment and training services

Vocational preparation or training should be provided as an essential element of a service system for young parents.

For some adolescent parents, regular employment and training services already available in the community will suffice. For others, more intensive service with accompanying social supports will be necessary if the adolescent parent, who is unlikely to have worked previously, is to move into a series of activities designed to lead to a job.

3.17 Coordination of employment and training services

Child welfare organizations that do not traditionally offer employment and training services should facilitate the referral of their clients to such services.

The agencies and programs most necessary for assuring that employment-related services are provided to adolescent parents are the local job training and placement agency, the vocational education programs of the public schools, and employment programs that may be administered by community organizations, community action agencies, or other social service agencies.

3.18 Components of employment and training services

The continuum of vocationally oriented services made available to at-risk, pregnant, or parenting teens should include job orientation and job readiness skills, job shadowing, vocational counseling and career development, skill training, and job placement assistance.

For many at-risk, pregnant, or parenting adolescent, the journey to eventual employment will require several years,

As with education and health care services, the importance of work opportunities during adolescence cannot be overemphasized. Such opportunities not only teach adolescents important lifelong lessons, but also provide young people with the chance to make a positive contribution to their families. The financial and psychological rewards of employment are often the key to helping many otherwise vulnerable youths to begin to plan their futures.

Community leaders must establish the partnerships necessary to assure that adolescents have available to them productive work opportunities.

Child Day Care

Quality child day care programs can provide services designed to ease the task of parenting for adolescents who are unprepared for that role, and can teach important child-

rearing skills through role-modeling of parenting behavior. Child day care programs can also help to identify developmental problems in the children participating in the program, and can stimulate the children's healthy development.*

3.19 Goal for child day care services

Pregnant and parenting adolescents should have available to them access to quality child day care services that can support them in their return to school or participation in employment-related training or jobs.

Child day care used by adolescent parents may be obtained from informal (family and friends), or formal (licensed) child care providers. Licensed child day care providers should meet the criteria set forth in CWLA's *Standards of Excellence for Child Day Care Services.*

The developmental learning goals of each child in a child day care program should be realized through the provision of opportunities to form relationships with other children and adults, to use various materials and equipment, and to increase levels of self-confidence and mastery. Children in a child day care program should have available to them the following developmental learning experiences:

- opportunities to obtain emotional support, warmth, and caring from others;
- exposure to adult models with whom they can identify;
- opportunities to work with tools or other objects from the natural environment, sometimes in play, sometimes in purposeful pursuits of the real world;
- opportunities to perform a variety of tasks so as to achieve competence in some skills;
- a balance of independence from and dependence on adults;
- a balance of free space, free time, and free choice;

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* See CWLA *Standards of Excellence for Child Day Care Services.*

- opportunities to assume individual and group responsibilities;
- interaction with other children, formation of friendships, and participation in group fun and planned activities;
- affirmation of their own heritage and culture and an acceptance and appreciation of them by others;
- opportunities to work at their own developmental level and pace, yet have appropriate challenges;
- opportunities to learn how to handle success and failure;
- opportunities for exploring, inventing, and pursuing individualized ideas and interest; and
- opportunities for organized recreational activities and individual and team sports for school-aged children.

3.20 Coordination of services

Child day care arrangements should be determined by the needs of the child and in the context of the adolescent parent's support program. If the child welfare organization does not itself provide appropriate child day care services, it should refer the pregnant or parenting teen to such services.

Establishing a plan for child day care is integral to the overall plan for meeting the parents' and the child's developmental needs. Child day care services can be a place for parenting education, and for improving relationships between parent and child.

3.21 Components of child day care services

The range of community child day care services available to adolescent parents should include infant care; center-based child day care; before- and after-school care; child day care for children with special needs, including children with handicapping conditions; child day care that emphasizes developmental experiences for the mother and the maternal-child bonding experience; parenting education; and services to assess the child for developmental delays.

The child day care setting and caregiver must provide a developmental learning environment that nurtures, protects, and educates the young child.

Development of a full range of child care options for infants of adolescent parents will typically require the involvement of family- and center-based child day care providers, the schools, and the social service programs that administer associated child care programs.

Children born to adolescent parents may need special care and stimulation in child day care programs due to a heightened incidence among these children of prematurity or low birthweight. The child day care provider should offer or facilitate access to screening of children for developmental delays, well-balanced hot meals, health screening examinations, and parenting education classes.

Child day care provided for children born to adolescent parents should include an educational component. These children often are cognitively less well-prepared to enter school and often show deficits in language use.

Children born to young parents often have multiple caregivers at home. Continuity of caregivers and routine in child day care give the children a sense of security and stability and should be emphasized.

Parental involvement in child day care is particularly important for both the young parents and the child. Through the child day care program, adolescent parents can learn how their children behave when they are away, and can become familiar with techniques to stimulate learning and coping skills. They may also meet other young parents with whom they can share resources and support. Regularly scheduled parent meetings in family- or center-based child day care programs should be held at times convenient to working parents and other caregivers.

Parenting education should be seen as an integral part of child day care programs. Parenting education can support teens in their role as parents and should address developmental needs of children, appropriate discipline, health care for infants and toddlers, and so forth.

Financial Assistance and Funding

3.22 Financial assistance

The child welfare agency should advocate in behalf of and help obtain financial assistance for pregnant adolescents or young parents and their children, and should assist the pregnant adolescent or young parent in obtaining financial assistance when such assistance is necessary for obtaining the essentials needed by the parents and/or their children.

3.23 Sources of funding*

To finance the system of services for pregnant adolescents and young parents, child welfare organizations should be prepared to pull together funding from diverse sources.

Federal funding of required services is inadequate. Advocacy efforts in this regard are most warranted and are strongly encouraged.

Federal funding sources available at this writing include:

- Social Services Block Grant funds, which flow to designated state agencies and can be used for direct services or to purchase service from private providers;
- Medicaid, which pays for the costs of health care, including prenatal care, delivery services, and the costs of hospitalization and postpartum services;
- The Education for All Handicapped Children Act (P.L. 94–142), which provides special education services, including "alternative" programs;
- The Adolescent Family Life Act (AFLA), Title XX of the Public Health Service Act, provides funds for programs intended to prevent premarital adolescent sexual activity; programs to assist pregnant adolescents and young parents in obtaining services such as health care, education, and vocational training; and research into the causes and consequences of adolescent sexual activity, pregnancy, and childbearing;

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* See CWLA *Standards of Excellence for the Management and Governance of Child Welfare Organizations.*

- Vocational Education funds, which flow to the State Educational Agency (SEA) and include earmarked resources for adolescent parents;
- Title IV-E of the Social Security Act, which provides a 50% federal reimbursement for residential care and other services for Title IV-E eligible foster children;
- The Independent Living Initiative for Title IV-E eligible children in out-of-home care, which can be used to provide services for adolescent parents;
- Job Training and Partnership Act (JTPA) funds, which are available to states and localities to target adolescent parents for employment and training program support;
- The Maternal and Child Health Block Grant (Title V of the Social Security Act), which primarily supports health and nutrition services for pregnant women, and for mothers and their children;
- The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), Temporary Assistance for Needy Families, which allows states to identify special-needs payments that may be provided for identified target groups of AFDC recipients (i.e., states may elect to make a special-needs payment for AFDC mothers under 18 years of age, attending school, preparing for a job, or obtaining employment); and
- Title X of the Public Health Service Act, which provides funding to health departments, clinics, and hospitals to support family planning projects and to increase accessibility for contraceptives, educational materials, and personnel training.

In addition to making use of these federal funds, some state have enacted legislation to finance state-based programs for pregnant adolescents and young parents. In states where these types of special programs may not have yet begun, child welfare organizations should take the lead in advocating for their enactment.

Private sector funding for services to pregnant adolescents and young parents is primarily provided by the United Way.

Child welfare agencies should explore the potential for obtaining new resources through cooperation with local corporations and foundations, religious organizations, and civic groups.

Evaluation

An evaluation provides the funding agency and the organization with documentation for determining the degree to which objectives were met and methods were followed. It also provides valuable information regarding the cost-effectiveness of the proposed program. An evaluation offers the program provider information with which to improve the program, narrow or expand the program's focus, and increase cost-efficiency.*

3.24 Evaluation planning

The child welfare organization should develop the capacity to evaluate its programs and should advocate for funding to support ongoing evaluation.

The evaluation plan is a tool that can be used to examine the impact of specific programs, interventions, and policies on a specific target population.

The evaluation plan assists the program provider in determining what components and modules of the program were actually implemented and what effect the program had on the population receiving the program's services.

3.25 Process evaluation

The child welfare organization should develop the capacity to assess its program activities (interventions) by determining the extent to which components and/or modules of the program were actually implemented.

Process evaluation is useful in determining if the program model is on target or if components or modules of the pro-

* See CWLA *Standards of Excellence for the Management and Governance of Child Welfare Organizations.*

gram need to be added, eliminated, or changed. The questions that follow may assist the organization in developing a process evaluation:

- Are appropriate personnel, equipment, and financial resources available in the right quantity, in the right place, and at the right time to meet program needs? If not, what obstacles are preventing these activities from taking place?
- Are expected "products" of the program actually being provided? Is the program providing the expected services and reaching the target population?
- What key ingredients contribute to the results being achieved?
- Are the activities being completed on time? Is the timeline adequate to reach the established objectives?[6]

3.26 Outcome evaluation

The child welfare organization should develop the capacity to assesses the results, effects, or impact of its program activities (interventions) on the target population.

Outcome or impact evaluations are useful in determining whether or not objectives were met and goals were achieved.

Relevant questions that should be asked as part of an outcome evaluation include:

Did the program meet its stated objectives?

What were the short-term results of the interventions?

Can the results of the program be attributed to the program itself (as opposed to other factors and influences)?

Is the adolescent parent empowered to obtain needed services?

Notes

1. National Center for Health Statistics. (1991). Advance report of final natality statistics. *Monthly Vital Statistics Report, 42*(3),

2. Boyer, D., & Fine, D. (1992). Sexual abuse as a factor in early pregnancy and maltreatment. *Family Planning Perspectives, 24*(1), 4–11.

3. National Campaign to Prevent Teen Pregnancy. (1996). Analysis of Henshaw, S.K., U.S. Teenage Pregnancy Statistics. New York: Alan Guttmacher Institute.

4. Maynard, R. A. (Ed.). (1996). *Kids having kids: A Robin Hood Foundation special report on the costs of adolescent childbearing.* New York: Robin Hood Foundation.

5. Maynard 1996.

6. Brandis, C. (1991). *Adolescent pregnancy prevention: A guidebook for communities.* Palo Alto, CA: Health Promotion Resource Center.

4

Social Work and Support Services

The community as a whole must reinforce and support individual and family efforts to discourage adolescent sexual activity and unintended pregnancy. Although the first line of defense and responsibility is the individual and the family, it must be acknowledged that individual and family values are shaped by general social and community norms. Thus, the community as a whole must be challenged to reaffirm its role in supporting the fundamental importance of the family and in reflecting the importance of moral standards and family values in society.

Community-based organizations such as religious establishments, sororities and fraternities, PTAs, and neighborhood associations should be actively involved in the development and delivery of programs to prevent adolescent pregnancy. They can play a crucial role in shaping values, in promoting parental and family participation, and in mobilizing the resources and resourcefulness of the community.

The effectiveness of community-based organizations in delivering human services programs—from Head Start to housing rehabilitation, to women's crisis services, to services to pregnant and parenting teenagers—has increased dramatically. Pregnant and parenting teenagers and their children may best be served by community-based organizations.

> Children and their families relate better to neighborhood institutions than to large bureaucracies.

Community-based organizations can create the informal networks and supports that instill the right messages about responsibility and can mobilize families, friends, and neighborhoods.

In the delivery of programs, community-based organizations often have a flexibility and scale of administration that encourage innovation and self-reliance.

Community-based organizations can provide program planning and policy development, service delivery and monitoring for pregnancy prevention, and services for pregnant and parenting teenagers.

Pregnant adolescents and young fathers facing the crisis of an unplanned pregnancy need the opportunity to carefully consider the full range of long-range options available to them: abortion, marriage, parenting the child alone or with family support, or adoption. A child welfare organization may provide one or more of the services needed and procure others for its clients through referrals, purchase-of-service agreements or other contractual arrangements. Provided services may include:

- counseling for the pregnant adolescent, the young father, and the extended family;
- marriage counseling for the pregnant or parenting adolescent;
- adoption-related services; and
- social work services for the young parents, their children, and their families.

Although a range of services should be available, not every client will need all the services; the services a client needs will depend on the particular goals set by the client and the social worker; the informal support and assistance available to the client from family, relatives, and friends; and the client's needs that remain unmet.

Providing Social Work and Support Services

4.1 Goal of social work and support services

Social work and support services provided during an adolescent's pregnancy should assist her in meeting the needs

arising from the pregnancy and in developing a plan that assures both the child's and the young parent's maximum development. Social work and support services provided after the pregnancy ends should focus on implementing an integrated and coordinated system of care for the adolescent mother, father, and child.

4.2 Case management services

Case management services for pregnant and parenting teens are a component of the core services support systems that should be provided to all pregnant and parenting adolescents, and should be used to bring together and orchestrate for effective use all the resources required by the client and detailed in the service plan.

Case management services may include assessment of needs, development of individual and family services plans, monitoring, and advocacy.

Case management services may be obtained from the child welfare organization, or, if that is not feasible, from consultants and community organizations.

4.3 Components of social work services

The child welfare organization should help to meet the social work needs of pregnant adolescents and young parents by providing assistance to these youths in locating community resources; handling physical, social, and emotional problems; understanding preexisting problems; obtaining resources and services; planning for the parents' and the child's needs; and establishing and maintaining relationships.

Social work services are one component of the continuum of services for pregnant and parenting teens.

The social worker should provide the pregnant or parenting adolescent with assistance in:

- locating community resources to meet immediate and individual need such as physical and mental health care, housing, financial assistance, legal services, schooling and employment, family counseling, mediation and negotiation, transportation, and child care;

- dealing with the specific stresses arising from pregnancy, pregnancy termination, or the birth of a child;
- gaining understanding about preexisting problems, including any history of maltreatment and family disruption that may have some bearing on the pregnancy or that may complicate the situation;
- obtaining resources and services needed for the child;
- reaching and carrying out a suitable plan for the child;
- planning for their own future with or without the child, and with or without each other; and
- forming meaningful and growth-producing interpersonal relationships with families, peers, and others.

Some pregnant adolescents or young parents may require and want help only in using available resources on a temporary basis; others may require continued social work services, especially if the child's welfare might otherwise be jeopardized.

Some pregnant adolescents or young parents may decide on a plan prematurely and without careful consideration of all options, only to later regret their lack of consideration of alternatives. While client self-determination should be respected, full discussion of all alternatives and the long-term consequences of each should be encouraged.

4.4 Recognition of client needs and strengths

Social work with pregnant or parenting adolescents and their families should be provided in accordance with the clients' individual needs, problems, motivations, strengths, and capacities.

To provide services effectively, the social worker must:

- understand the situation, including the client's present realities and her or his life experiences that bear upon it;
- identify (1) the capacities and strengths of the pregnant adolescent to meet the tasks and responsibilities of her pregnancy, with due regard for her rights and concerns; (2) the capacities and strengths of the young father to meet the responsibilities of his relationship with the young woman and with the child;

(3) the factors in the young mother's and father's environment that may help or hinder them in meeting their present responsibilities, (4) the problems of the young mother and father that may be anticipated before and following the birth of the child; and (5) the family support systems that will assist the adolescent mother and young father as they prepare for their parenting duties;

- assist in the formation of a course of action to cope with the needs and the problems of the adolescent parents and their child, which can be carried out in the context of the resources and realities of the situation; and
- assist the young parents in carrying out the chosen plan.

4.5 Role of the client in service planning

The social worker and pregnant adolescent or young parents should set goals for the service, agree on a plan for achieving them, and establish a period of time for evaluating the use of the service and the need for further assistance.

Generally, the pregnant or parenting adolescent and/or the father will be expected to participate in the planning of services.

The participation of both families depends on their involvement with the pregnant adolescent or young parents. The willingness of family members to participate in services should be respected, whether or not they are living with one of the young parents.

The social worker and pregnant adolescent or young parents should establish regular intervals for shared evaluation and set up a method by which they can discuss their evaluations and arrive at a basis for future planning.

In community-based programs, social workers should meet biweekly with clients to assess the plan and the progress toward the client's goals. Joint evaluation with cooperating agencies should also take place regularly.

The social worker should continually evaluate the relationship with the pregnant adolescent or young parents and the

care of the child. The social worker should be close enough to the parents to understand their responses, but detached enough to perceive, evaluate, and respond appropriately.

The social worker should review and record the experience with the clients in interview or group activity, and should use supervision or consultation for periodic evaluation.

4.6 Social work methodology

Social work methods, including individual counseling, family counseling, case management, and group practice or other methodologies, should be selected according to the needs of the pregnant adolescent, father, or young parents, and in relation to their purpose in seeking help.

Individual counseling can help the pregnant or parenting adolescent, and/or the father, to focus on individual or family problems, to consider the choices that may be helpful to them, and to develop productive ways of using those choices in their circumstances.

Family counseling, provided through a variety of family treatment methodologies, can help the entire family system of which the adolescent is a part to address problems and pursue individual and family member goals, as well as the goals of the family as a whole.

Case management services should be provided to coordinate the delivery of services to achieve effective management of and accountability for services, to eliminate gaps in the availability of services, and to ensure that services are available to pregnant and parenting adolescents.

Group counseling can provide a setting in which leadership, organized contact, and peer group interaction can be used. The group method differs from the individual relationship in that members of the group are enabled to help each other. The purpose of the group, as well as the role of group leadership, should be clearly defined, and a structure selected that best suits those purposes.

Groups have been used successfully for the provision of education, orientation, and information; counseling and emotional support; and psychotherapy.

4.7 Caseloads

The child welfare organization should establish average caseloads of 20–25 cases (the pregnant adolescent, father, or young parents, their children, and their families) for one social worker providing casework, family counseling, case management, and group practice services, as required. Workers addressing specialized client needs may require lower caseloads.

4.8 Staff qualifications

The personnel providing service shall be appropriately qualified to carry out the agency's program of services. Personnel covered by these standards include both volunteer and paid staff of service provider agencies, professional and paraprofessionals, administrative staff, and direct service staff.

All paid direct service staff should have at least a bachelor's degree in social work, psychology, counseling, or a related social service field.

All personnel providing clinical counseling services should be licensed or certified in accordance with state law governing clinical practice.

All personnel providing medical care should be certified in the health care field.

All paraprofessional support staff should have a high school diploma or GED and should be certified in the direct service that they provide. Staff members who are to work 10 or more hours per week should receive training in the particular service they will be providing.

4.9 Staff training

The organization should provide its staff with adequate and appropriate ongoing training. Prior to commencing employment, all direct service staff should receive an orientation to the program. Within 90 days of employment and annually thereafter, all paid and volunteer direct service staff should be trained in CPR for infants and children, and in staff boundaries, appropriate relationship with youths, adolescent development, and community resources.

Supervisory and direct service staff should receive at least 20 hours of training annually.

Counseling the Pregnant Adolescent

Any young woman experiencing the crisis of an unplanned pregnancy needs support, encouragement, and counseling as she examines the long-term pros and cons of each option regarding resolution of the pregnancy (abortion, marriage to the father of the child, parenting alone or with the support of family and friends, or adoption).

Given the developmental stage of the pregnant adolescent and the crisis nature of an unplanned pregnancy, decision making usually progresses in an uneven fashion (i.e., one week marriage may seem to be the answer, the next week adoption may seem to be the best plan). The opportunity to explore various alternatives is an essential aspect of pregnancy counseling that can lead to soundly made decisions.

Pregnant adolescents need to be encouraged to think about both the immediate effects of their decision and to anticipate how they might feel about their decision in one year and in 20 years.

One strategy, in addition to individual and family counseling, is to provide opportunities for pregnant adolescents, the fathers, and extended family members to hear of firsthand experiences from other adolescents who have decided to parent their children, adolescents who have released their children for adoption, and possibly adoptive families. Often this is accomplished by an agency offering a series of panel presentations and discussion groups.

4.10 Goal of counseling for the pregnant adolescent

The pregnant adolescent should be provided with individual and group counseling: (1) to help her cope with the ramifications of the pregnancy and to become aware of the options in relation to pregnancy resolution (termination of the pregnancy or carrying

the pregnancy to term) (2) to help her recognize her options if she decides to carry to term, including parenting the child (alone or with the father of the child), planning for the adoption of the child, or allowing guardianship to be taken by a family member; and (3) to provide guidance, encouragement, and services that will promote healthy development by facilitating her choice of resolution, school completion, satisfactory employment, positive peer and family relationships, financial stability, good physical health, and heightened self-esteem.

4.11 Counseling concerning pregnancy resolution

The pregnant adolescent should be counseled about all alternatives regarding the pregnancy's resolution.

Counseling regarding the pregnancy's resolution should begin as early as possible in the pregnancy. Counseling should span at least several sessions to allow for a full discussion of each alternative, the legal implications of each choice, and a full exploration of the client's situation and attitudes, those of the father, and those of both of their families. Given the crisis nature of an unplanned pregnancy for many adolescents and their families, the feelings of all those concerned may well change over the course of the pregnancy and thus influence decision making. It is essential that the client be given sufficient time to consider each option.

Counseling regarding the pregnancy and its aftermath is best conducted on an individual basis to permit the fullest exploration of each involved person's feelings. Group counseling, however, can be helpful, as it provides the client with the support of peers in the same situation, and allows the sharing of fears and questions.

The pregnant adolescent should not be pressured or coerced into making a decision regarding her pregnancy. Neither should services be denied or withheld because of her decision.

If an organization is opposed to the termination of a pregnancy, it should refer the client to another organization to receive counseling.

4.12 Counseling on termination of pregnancy

If the pregnant adolescent decides to terminate her pregnancy, arrangements should be made for a legal procedure by a qualified medical professional as early in the pregnancy as possible (see Chapter 5).

Early in the counseling process, agencies should make known their policies regarding termination of pregnancy. Staff members who are unwilling or reluctant to discuss termination with a client on ethical or religious grounds should not be expected to do so. In these cases, the staff member should refer the pregnant adolescent to another staff member or organization that is willing to provide the support the client wishes.

Counseling concerning termination of the pregnancy should include the father whenever possible. He should be seen separately and together with the pregnant adolescent.

Counseling sessions should focus on the client's attitudes and belief about termination, the finality of the decision, the basis of the medical procedure (including associated risks and beliefs of childbearing), and future planning in relation to sexuality and contraception.

Posttermination counseling should be encouraged to assist the client in the grieving process.

4.13 Counseling on carrying the pregnancy to term and planning for parenting

If the client elects to carry the pregnancy to term and to parent the child, the organization should provide or facilitate access to counseling that stresses the importance of early and consistent medical care and adequate nutrition, and should help the client to obtain such services.

The pregnant adolescent should be advised that her decision to assume parental responsibility does not have to be final, and that adoption and other alternatives remain should she later change her mind. The father of the child should also be so informed.

In the last months of pregnancy, the pregnant adolescent and the father should be strongly encouraged to attend childbirth classes on labor and delivery, as well as classes in ba-

sic infant care. Plans for delivery in an accredited hospital and return home should also be covered in counseling sessions.

If a decision to parent the child is made, the family relationship should be fostered and preserved. Thus, if the pregnant adolescent choosing to carry to term shows the potential for being an adequate parent, her right to do so should be respected. In situations where the adolescent's capacity for child caregiving can be seriously questioned, the infant's right to protection and a nurturing environment must be paramount, and the options of adoption or temporary out-of-home care until the mother is able to provide adequate care should be discussed.

Discussion of adoption should not be limited only to those situations where there is a question about the adolescent's capacity to parent.

4.14 Counseling on carrying the pregnancy to term and planning for adoption*

The social worker should present adoption as a positive option during counseling sessions and should educate young parents about the availability of this option both before and after the birth of the child. If the client elects to carry the pregnancy to term and decide on adoption for the child, the organization should provide or facilitate access to counseling to help the young parents prepare for the transfer of parental rights to an agency or other authorized body, complete the legal termination of their rights, design a plan for open adoption if desired, and cope with the emotional issues of separation and the sense of loss arising from foregoing the future parenting of the child.

It is estimated that fewer than five percent of adolescent mothers select adoption for their child.[1]

The availability and prevalence of open adoption, in which the biological parent continues to receive information about the child placed for adoption or in many instances, continues to have a relationship with the child following adoption, should be explained. The degree of openness in an adoption may range from specifying criteria for parents; to

* See CWLA *Standards for Adoption Service.*

selecting one of a group of home studies; to meeting with prospective parents and sharing medical, social, and other background information that has importance for the child; to having a continuing relationship with the child following the adoption.

Both the biological parents and the adoptive parents have a voice in whether they wish contact with each other and the child and/or an exchange of knowledge about each other. Arrangements for open adoption are most successful when carefully planned.

Openness in the adoption process may help biological parents feel involved in the selection of the adoptive parents. It may help as well to satisfy a parental desire to receive information on the child's future development on an ongoing basis and thereby also facilitate a more stable acceptance of and reaffirmation regarding the adoption decision.

Counseling and other appropriate postlegalization adoption services should be made available to the biological parents after the transfer of parental rights and after the adoption is complete, to help them deal with the effects of separation from their child, the grieving process, and adjustment to open adoption if this plan has been selected.

4.15 Counseling the pregnant adolescent about her own development

In addition to receiving counseling on pregnancy resolution, the pregnant adolescent, regardless of her decision about the pregnancy's outcome, should receive counseling about her own development (personal adjustment, education continuation, self-esteem, job training or placement, sexuality and family planning, and peer and family relationships).

The social worker should help the adolescent to identify realistic goals and clear objectives, and a plan for achieving them. The worker should also advise the client about services at the agency and elsewhere that will help her to meet her objectives.

For example, high school completion should be a minimum goal for all clients, with college, vocational training, or employment plans made for those 18 or over

with a high school diploma. Older adolescents and young women who have not completed high school should plan to prepare for and pass a General Equivalency Diploma (GED) exam, or should plan a remedial program and then move on to additional schooling or employment.

The worker and the client may find it beneficial to outline in a written contract what each is expected to do, including a timeline for completing tasks.

Special attention should be directed in counseling to family planning, peer and family relationships, and the reasons the client became pregnant. This is of paramount importance in reducing the possibility of repeat pregnancy. If the father and extended family can be involved in counseling sessions, they, too should be made aware of the pregnant adolescent's goals and objectives and the ways in which they can facilitate their fulfillment.

Counseling the Father

4.16 Goal of counseling for the father

The father should be provided with individual, family, or group counseling that (1) informs him fully of all options concerning the pregnancy; (2) supports his decision to father the child by providing (unless refused by the father) parenting skills training, childbirth support, assessment, and referral for substance abuse problems; and (3) provides guidance and access to services to help him with his own development (personal adjustment, education, employment, health, and peer and family relationships).

4.17 Counseling the father in relation to pregnancy resolution

The father should be counseled about the possible alternatives regarding resolution of the pregnancy.

Much of this counseling can be conducted effectively together with the pregnant adolescent. The pregnant young woman and the father should be counseled separately on several occasions, however, so that their individual feel-

ings and attitudes about the pregnancy, each other, and their own needs can be explored. If it is not possible to see the father with the pregnant adolescent, he should be seen individually.

Discussions with the father should address his rights and responsibilities with respect to pregnancy resolution alternatives, his ability to be a parent, and his relationship with the pregnant woman and her family, including the pros and cons of marriage. At no time should the father and pregnant young woman be forced or coerced into attending joint counseling sessions. Counseling of the father by a male professional may be particularly effective.

4.18 Counseling the father about his own development

The father should receive counseling about his own development (personal adjustment, high school completion, additional education, job training and placement, self-esteem, sexuality and family planning, and peer and family relationships), and if necessary, family mediation.

The father should be approached as a person with his own needs and problems, not simply as an adjunct to the pregnant adolescent's plan. The extent of his relationship with the pregnant adolescent should be fully explored to see how each might enhance or impede the other's development and realization of objectives. The extent and duration of their relationship will also influence how much the two should be seen for joint counseling.

Special group programs that use male staff leaders have proven effective and are encouraged.

4.19 Counseling the father about his legal rights and responsibilities

The father should be helped to obtain legal advice concerning his rights and responsibilities in relation to the child, including his child support obligations.

The child welfare organization, with the assistance of its legal counsel, should prepare a pamphlet outlining the legal rights and responsibilities of fathers, including pater-

nity establishment and child support, written to conform with the laws of the state or province where the organization provides its services. Such a guide might also include information on how and where to obtain legal counsel.

Counseling the Extended Family

4.20 Goal of counseling for the extended family

Members of the pregnant or parenting adolescents' extended families should be provided with individual, family, or group counseling that (1) informs them of the pregnant adolescent's options regarding the pregnancy; (2) assists them in supporting the adolescent in making a decision and carrying out the plan, and (3) enlists their support in realizing the goals for the adolescent's development.

4.21 Counseling for the extended family

Members of the pregnant adolescent's or father's families who are involved in significant relationships with the clients should be involved in counseling regarding the pregnancy.

As in counseling with the pregnant adolescent and the child's father, other family members should be made aware of the positive and negative aspects of all options. Their feelings regarding the pregnancy and family relationships, and their willingness to provide emotional, financial, and child care assistance, should be explored.

Although it is at times preferable to counsel the other family members with the pregnant adolescent and the father, such counseling should not be required. The extended family members should be seen on their own for some sessions to allow for a full discussion of their attitudes and feelings.

Marriage Counseling for Pregnant or Parenting Adolescents

4.22 Goal of marriage counseling

Marriage counseling should be provided to the pregnant or parenting adolescents to facilitate discussion of concerns

regarding any planned or existing marriage, and to provide them with the support they need to make decisions about those concerns.

4.23 Counseling on issues regarding marriage

The pregnant adolescent and the father should be provided with premarital counseling about the potential problems and positive experiences they may face in a marriage relationship.

Despite the significance and duration of some premarital relationships, the pregnancy of an adolescent may impose undue social, emotional, and financial strains on a youthful marriage.

Premarital counseling should be designed to help the clients focus on exploring the meaning of marriage, expectations of the prospective marital partners, and the problems often associated with marriage at a young age.

Depending on the age of those involved, parental consent or other legal permissions for marriage may be required. Thus, it may be necessary for the family to be involved in counseling if a marriage of minors is planned.

Counseling after marriage may be needed to help the couple manage stress relating to the marriage, such as financial or sexual concerns and the responsibilities of committed relationships and parenting.

Adoption-Related Services*

Adoption can provide a safe, nurturing permanent family without delay for each child whose parent cannot or chooses not to rear him or her.

Adoption counseling with a pregnant adolescent ensures that a sound, long-term plan is developed for both the child and the adolescent parents. To the extent possible, the father of the child should be involved early in the counseling process.

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* See CWLA *Standards for Adoption Service.*

Current and accurate information about open adoption and openness in adoption should be shared with the clients. In the majority of infant adoptions in the U.S., the biological parents of the child play a role in selecting the adoptive family, share relevant medical and social background information, often meet the parents, and frequently continue to have an ongoing relationship with their child.

4.24 Timing of the transfer of parental rights and responsibilities

If possible, the transfer of parental rights and responsibilities should take place soon after the birth of the child, for the benefit of the child, the biological parents, and the adoptive parents.

Early placement enhances the bonding process between the adoptive parents and the infant.

If the biological parents have received adequate counseling during the pregnancy and have reached a decision prior to the birth of the child, prompt transfer of parental rights may be possible. The biological parents, however, should be given sufficient time following the birth of the child to ensure that their decision is not made under pressure.

The timing of the transfer of parental rights will be influenced by state law, with some states providing a longer minimum time following delivery than others for the transfer of parental rights. Mothers should be allowed time to ensure that they have sufficiently recovered from childbirth before giving informed consent.

Biological parents should be strongly encouraged to see their child following the child's birth. The reality of giving birth and then releasing a child for adoption, even if the parents are convinced it is the best plan for all concerned, is a painful experience. While seeing the baby may evoke additional feelings of grief, these feelings are often better expressed than suppressed. Counseling should focus both on support for the biological parents through the grieving process and support for their decision to place their child for adoption.

Services should be made available to all parties following the adoption decision and placement.

4.25 Establishment of paternity

Questions regarding the paternity of the child should be resolved as quickly as possible. Once paternity has been established, the father should be given a full opportunity to receive counseling prior to his making a decision regarding his parental rights.

Counseling for the father should focus on such issues as his interest in being involved in decisions about the child, any feelings of guilt or conflict he may be experiencing, his interest in asserting his parental rights, and the full range of his possible roles and responsibilities.

4.26 Parental participation in providing background information

Both biological parents should be strongly encouraged to make available information about their child's background, including their own medical and developmental histories as well as relevant social and educational information.

The value of providing social and medical background information should be emphasized and such information promptly secured.

Information obtained from the biological parents should be shared with the adoptive parents for the later benefit of the child.

After the adoption is legalized, the biological parents should be encouraged to continue to provide relevant background information to the organization to share with the adoptive family.

4.27 Parental participation in the transfer of parental rights and responsibilities

The advantages of voluntarily participating in the transfer of parental rights should be explained to both parents and encouraged if adoption is selected as the plan.

4.28 Protection of the finality and legality of a voluntary transfer of parental rights and responsibilities

The voluntary transfer of parental rights and responsibilities for a child should be accepted only when (1) the biological parents

have received appropriate counseling, regardless of the age of the child, (2) the biological parents have been given sufficient time to make an informed decision that is best both for themselves and for the child, and (3) the biological parents recognize that their decision is final.

The parents' relinquishment of their parental rights should be accepted only when the social work professional considers the parents to be emotionally ready to end their rights, as well as their responsibilities, as parents of the child.

Documentation citing the results of multiple discussions with the parents, and including the time, content, place, and manner of those discussions, should be maintained to demonstrate that all issues were discussed thoroughly, without pressure, and that the parents were provided with an appropriate amount of time to consider their decision.

A third party from the agency should be present at the relinquishment.

The use of informal arrangements that result in postponement of the time of permanent termination of parental rights until entry of the adoption decree is hazardous and should be discouraged; such arrangements do not serve the interests of all the parties involved.

If it is later found that adoption is not a suitable or possible plan for the child, the biological parents should be asked whether they wish to be reinvolved with the child. The child welfare agency accepting legal responsibility for the child should retain responsibility for the child until another appropriate plan is made.

4.29 Involuntary termination of parental rights

When a determination has been made that in all probability the biological parents are unable to fulfill their parenting responsibilities, but the biological parents are unwilling or unable to voluntarily transfer their parent rights for the child, the child welfare organization should promptly petition the judicial system to act in the interest of the child by involuntarily terminating the parents' rights.

4.30 Protection of parental rights in the event of involuntary termination

If proceedings to involuntarily terminate parental rights are necessary, the organization should ensure that all legal requirements regarding notice and due process are followed, consistent with state law, in order to safeguard the rights of all parents.

4.31 Right to consent to adoption

Concurrent with any judicial action terminating rights, and where permitted by state law, legally binding action should be taken to transfer responsibility for the child to a child welfare organization authorized by law to assume both the power and duties of legal custody, and authorized to consent to the adoption of the child without the further consent of the parents or their appearance in court.

Support Services for Young Parents, Their Children, and Their Families

4.32 Goal of Support Services

The goal of individual, family, or group counseling for young mothers and fathers should be to help the young parents set goals and objectives for their own development (i.e., high school completion, additional education or vocational training, employment, physical health, family planning, and peer and family relationships); to provide directly, through purchase of service, or through referral, access to services that enable the young parents to progress toward their personal goals and objectives; to offer the young parents child care and child development education, and support in parenting so that they might provide a safe and stimulating environment for the child; and to help the young parents to cope with the combined emotions, stresses, and problems of adolescence and parenthood.

4.33 Involvement of both parents

Both the young mother and father should be seen by a social worker or counselor after the birth of the child.

The young mother and father should be seen together in counseling sessions following the birth of the child, if possible, whenever they continue to have a relationship and share responsibility for the child.

The parents should not be forced to be seen together, however, and joint counseling should not be mandatory for the receipt of this or any other service.

The young parents should also be seen individually so that they have the opportunity to discuss any issues they do not wish to share with their child's other parent.

4.34 Involvement of grandparents and extended family

Members of the young parent's families who are involved in significant relationships with the clients should be involved in counseling and in providing financial support when able.

Parents of adolescent parents (the grandparents of the child) may be uniquely involved in caring for the child, as they may continue to have parental responsibilities or influence in relation to the adolescent. Their involvement in counseling and in other social support services provided to the adolescent parents is critical, and may be a determining factor in the success of the service plan developed for the adolescent parents.

Other extended family members who have close involvement with, or influence upon, the adolescent parents' choices should be involved in the provision of services.

4.35 Counseling directed toward goals and objectives

Counseling should be focused on specific goals and objectives mutually determined by the social worker and young parents.

Written contracts and progress reports detailing the clients' goals and objectives are particularly helpful, so that incremental steps toward meeting them can be recognized and serve as a concrete reminder of the purpose for obtaining support. The use of identified goals and objectives can also make the delivery of services more effective and efficient.

The age of the client should be considered in determining the goals and objectives. Older adolescents are better able

to articulate their needs for services and future plans than their younger counterparts. Most younger adolescents may find it hard to be realistic about their futures, and social workers will have to support the level of direction in their role with these younger clients.

All adolescents should strive to achieve certain goals and objectives, including a high school education and diploma or its equivalent; a postsecondary education or job training leading to economic self-sufficiency; placement in a job with the potential for self and family support; heightened self-esteem; adequate medical care to enhance good physical health; prevention or delay of pregnancy until they are prepared to create healthy, productive futures for their children; positive peer and family relationships; and adequate nutrition and shelter.

4.36 Focus on the strengths of the young parents

Counseling should focus on the strengths of the young parents.

Too often a long list of problems is all that is associated with adolescent parenting. Social workers must not lose sight of the young parents' positive behaviors and personal strengths (i.e., attending school every day, juggling child care, maintaining appointments). Young parents need support and reinforcement for what they are doing well, such as identifying their strengths and extending their influence to other behaviors.

4.37 Counsel on accreditation provisions

All social work services provided or obtained by the child welfare agency should meet the relevant CWLA standards, as well as the provisions of the Council on Accreditation of Services for Families and Children, Inc.

Note

1. Alan Guttmacher Institute. (1994). *Sex and America's teenagers.* Washington, DC: Author.

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Health Care Services

The three major goals of medical and health care services for pregnant adolescents, young parents, and their children are (1) to provide routine, preventive, and emergency health care of high quality to the client and child; (2) to provide education and support on health care issues so as to enhance self-care and preventive health behaviors; and (3) to reduce repeat births to the adolescents.

5.1 Responsibility for meeting health care needs

The child welfare organization that serves pregnant adolescents, young parents, and their children should share responsibility with health care organizations, pediatricians, obstetricians, gynecologists, adolescent medicine specialists, and other professionals providing health care and medical services to its clients to ensure that all of its clients' health care needs are met.

5.2 Integration of social work and health care services

Health care services should be integrated into the case plan with social work services so that an exchange of pertinent information can take place freely and both services can work harmoniously for the same goals.

Physicians, social workers, and other professional staff members involved in the provision of medical care and other health care services should foster a mutual understanding of, and respect for, the contributions of each other.

5.3 Sources of medical care

The child welfare organization should assist the pregnant or parenting adolescent in obtaining medical care from a physician (preferably an obstetrician, gynecologist, pediatrician, or adolescent medicine specialist).

All health care providers should meet accepted standards of medical practice.

The adolescent should be given a choice of medical resources and health care providers if possible. Providers of medical services may be in private practice or employed by clinics, hospitals, or other health care facilities. Maintaining continuity of care should be emphasized.

Adolescent parents who choose to raise their child should be provided with assistance in using community resources that offer health care services for them and for their child, including pediatricians, obstetricians, maternal and infant care centers, community health centers, well-baby clinics, visiting nurses practitioners, nurse midwives, public health workers, and the social service departments of hospitals and clinics.

The social worker should assist the pregnant or parenting adolescent in getting to necessary medical appointments and should verify that appointments are kept.

Basic Requirements for Medical Care

5.4 Standards of medical care

Medical care should conform to the standards established by the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics.[1]

Prenatal care should be provided by or under the supervision of a physician or duly licensed clinic.

Services provided to pregnant or parenting adolescents should be responsive to their medical and special needs and should focus on preventive health care behavior. A full range of medical and health care services should be available to pregnant or parenting adolescents and their children, including:

- screening for high-risk conditions;
- services to terminate pregnancy;
- prenatal care;
- medical laboratory services;
- labor and delivery services;
- postpartum care;
- diagnosis and treatment of all medical problems;
- dental examinations and treatment;
- pediatric care for the baby, including immunizations and routine well-baby visits;
- routine medical checkups for young parents;
- access to emergency care;
- medical social work services;
- allied health care services, including nutritional guidance, exercise, first aid and CPR instruction, and nursing and health instruction;
- family planning services;
- nutrition assessment;
- care coordination and follow up;
- health promotion;
- transportation services;
- genetic risk identification and referral;
- substance abuse identification and referral;
- childbirth preparation classes;
- home assessment/client education;
- smoking cessation counseling;
- Alateen and Alanon groups; and
- mental health care services.

5.5 Services to terminate pregnancy

The medical facility that provides pregnancy termination services must provide services that are safe, legal, and protective of the adolescent's rights to privacy, confidentially, and full information.

Prior to the termination of the pregnancy, the service provider should inform the client about the procedure to be used, including possible complications; obtain informed consent; and confirm that it is the client's own decision to have the procedure.

The procedure should be conducted as early as possible in the pregnancy to minimize risks.

Counseling should be an integral component of pregnancy termination services. Counseling should be provided to help the pregnant adolescent explore the various factors that are involved in her decision to terminate her pregnancy.

Counseling regarding family planning and birth control should be an integral component of pregnancy termination services; the provision of contraceptives at the time of termination, or soon thereafter is strongly recommended.

In structuring their services, organizations or facilities providing pregnancy termination services should implement policies that protect an adolescent's confidentially, and should offer flexible appointment hours and payment plans.

5.6 Prenatal care

Prenatal care should be available to all pregnant adolescents.

Prenatal care should begin as early as possible in the pregnancy and should follow a regular sequence, such as that delineated by the American College of Obstetricians and Gynecologists.[2]

Although the effects of prenatal care are difficult to measure,[3] early comprehensive care can promote healthier pregnancies by detecting and managing preexisting medical conditions, providing health care advice, and assessing the risk of pregnancy complications such as low birthweight and preterm birth.[4] Prenatal care can be crucial to maternal health and can serve as a gateway into the health care system, especially for socially disadvantaged women.[5]

National objectives have been developed to emphasize the importance of making prenatal care available to all women. The U.S. Surgeon General has called for an increase by the year 2000 in the proportion of women by age, racial, and ethnic risk groups who receive care in the first trimester.[6]

Programs serving pregnant adolescents should seek to increase the percentage of their clients receiving first trimester prenatal care through engagement retention activities.

The agency or medical facility offering prenatal care should make available, either directly or through referral, comprehensive services that include pregnancy testing; treatment of health problems that develop during pregnancy; nutritional guidance; counseling regarding drug, tobacco, and alcohol use; exercise programs; genetic counseling; routine checkups; emergency treatment; and mental health services.

Educating the adolescent parents to assist them in preparing for childbirth should be an integral component of prenatal care. Such education should include discussions about anatomy and physiology, the developing fetus, pregnancy risks, developmental changes, the experience of childbirth, personal hygiene, and so forth. In particular, emphasizing proper prenatal nutrition can do much to alleviate later problems.

This information is best delivered by trained medical staff, such as doctors or nurse practitioners, but can be conveyed by others.

During pregnancy and at the time of delivery, when feelings are heightened, the pregnant adolescent has, in addition to any other problems, the same conflicts, fears, and patterns of relating as other pregnant women. Special medical provisions by clinics and hospitals for young adolescents can be helpful.

5.7 Contraceptive services

Because young women who experience repeat pregnancies are at particular risk of social and economic disadvantage, priority should be given to providing contraceptive services and identifying ways to effectively motivate these women to avoid repeat pregnancies.

During the last trimester of pregnancy, the health care provider and the pregnant adolescent should decide on appropriate family planning methods to be used following the birth of the child. Both before and after the birth of the child, counseling should be provided to reinforce the clients' decision.

5.8 Parenting classes

The prospective father and mother should have an opportunity to attend parenting classes to learn how to care for themselves and their child. The classes should address issues related to the responsibilities of parenting and sexuality.

Topics covered in parenting classes may include: caring for a new baby; immunizations for babies and children; safety in the home for babies and young children; infant development; sexually transmitted diseases; abstinence and contraception; parenting and discipline; good nutrition for babies; good nutrition for parents; how to handle stress; and future goals and aspirations.

5.9 Labor and Delivery

The pregnant adolescent's labor and delivery should take place in an accredited hospital, rather than at home or in a birthing center or other location, in recognition of the adolescent's higher risk of complications.

Well in advance of delivery, arrangements for hospitalization should be made with the assistance of the medical care and/or social service staff.

5.10 Postpartum care

The social worker should arrange for the adolescent to receive, after delivery, appropriate health care, contraceptive services, instructions on diet and exercise, and any indicated treatment.

A postpartum visit should be routinely scheduled two to six weeks after delivery. The child welfare organization, in cooperation with the medical professional, should inform the young mother of her need for adequate postpartum care for her sake as well as that of her child.

During the postpartum visit, family planning methods should be evaluated and monitored for compliance.

The child welfare organization should help the client to set an appointment date for postpartum care before she leaves the hospital and should make reminder telephone calls to reinforce the keeping of that appointment.

5.11 Pediatric care for the baby

Appropriate pediatric care should be provided for the baby before and after discharge from the hospital, whether the child is with the mother, in out-of-home care, or placed for adoption.

The pediatric care provider should give the mother information and educate her about the importance of well-baby care and should help to promote positive health behaviors for the child's well-being.

The pediatric care provided should be accessible and available 24 hours a day.

Parents who have decided to raise their child should be given instruction in child care methods.

In addition to the private pediatrician or physician, various community resources such as infant care programs, well-baby clinics, nursing services, or public health agencies may provide pediatric care. Local health and/or education departments may administer screening tests to identify developmental delays.

Infants who were exposed to drugs or alcohol prenatally may need specialized observation or treatment. Their parents will need to be taught how to care for them, and in particular, should receive instruction on comforting a fussy baby, obtaining specialized medical care treatment, and assessing the child for developmental delays.

The social worker and health care professional should collaborate to develop a plan for monitoring the adolescent parents and the child, including plans for a home visit to assess the home environment, the establishment of support systems by other family members, and the formulation of a treatment plan for the mother and child (if necessary). The young parents and their child should be closely monitored via home visits and services provided to them as needed.

5.12 Childhood immunizations

The child welfare organization, together with the health care provider, should assure that all children born to young parents have been immunized against common childhood illnesses by the age of 24 months, or as otherwise medically indicated.

Many young parents question the need for immunization in view of the current low incidence of some illnesses and the cost of pediatric care. The parents should be told of the risks to their children of not being immunized, and assisted in obtaining free or low-cost care.

5.13 Routine medical checkups for the infants of young parents

The adolescent parents should be encouraged to obtain routine medical checkups for their child in accordance with the schedules proposed by the American Academy of Pediatrics.[7]

Parents should be informed that routine checkups and preventive care are necessary even though nothing may be physically wrong with their children. The social worker should counsel the young parents and work with them to overcome any impediments to seeking care (i.e., cost, transportation, lack of medical care provider, fear). If necessary, the social worker should make medical appointments and/or take the young parents and their child to such appointments.

5.14 Routine medical checkups for young parents

The adolescent parents should be encouraged to obtain routine medical checkups for themselves.

Young parents may be more inclined to take their infants to appointments than to go for checkups for their own well-being. It may be useful, therefore, for the health care provider at the child's visit or for the caregiver to encourage the parents to get well-care for themselves, as well as to discuss their family planning needs.

At a minimum, adolescent parents should receive an annual physical exam. Service providers should bear in mind that many adolescent parents, like their infants, are still in a period of physical growth.

5.15 Responsiveness to adolescents' health care needs

Medical service providers selected to provide care for pregnant and parenting adolescents should be responsive to the special

health concerns of this population and should be knowledgeable about adolescent development.

The health care needs of this population are often overlooked. Flexible hours of services, cost of care, payment schedules, and confidentially are particularly important.

5.16 Access to emergency care

Adolescent parents should be taught how to use emergency health care appropriately.

Some young parents may use hospital emergency rooms as primary sources of health care. Such use should be discouraged and the use of a regular physician of pediatric clinic pursued.

Young parents should receive instruction in recognizing health care emergencies in themselves and their children, and in the action required in emergency situations.

5.17 Focus on preventive health care behavior

Health care services provided to young parents should include education and support services concerning preventive health care behaviors.

The subjects of diet; drug, alcohol, and tobacco use; exercise; and infant safety and nutrition should be given particular attention.

Family planning services, with an emphasis on preventing repeat pregnancies, should be offered to the young parents, and the prevention of sexually transmitted diseases stressed.

Service providers should work with the adolescent to establish health care behaviors for a lifetime.

Medical Social Work Services

5.18 Responsibilities of the social worker during the prenatal period

The social worker should emphasize to the prospective parent the importance of early and continuing prenatal care and hospitalization and should assist the parent in obtaining such care.

Care may be obtained from public, private, or nonprofit health care facilities.

When care is obtained from a private physician, or when the hospital or clinic lacks a social services department, the social worker should help the expectant parents explain to the doctor what he or she should know about the parents' social situation and special needs, attitudes, problems, and feelings.

Communication among the doctor, the prospective parents, and the social worker is essential for carrying out recommendations for prenatal care in such matters as diet, exercise, and specialized treatment. Nursing staff and public health nurses may be of assistance in interpreting recommendations and in helping the prospective parents to implement them.

5.19 Cooperation with the hospital at the time of delivery

To help the pregnant adolescent obtain adequate medical care during delivery, the social worker should know the hospital policies and strive to work within them.

If there is a hospital-based social services department, the child welfare organization's social worker should work in cooperation with it. If no hospital-based social services department is in place, the social worker should be prepared to interpret individual situations to hospital personnel whenever the need arises.

The social worker should help the prospective parents provide information so that the hospital staff can decide whether the parents are eligible for its services, and should ensure that the pregnant adolescent is registered for hospital care in advance of the need for hospitalization.

The social worker should work with the hospital staff to help the clients complete a discharge plan by the time the mother and child are ready to leave the hospital. The hospital should not be expected to provide hospitalization for either the mother or her baby beyond the period when such care is medically necessary.

The social worker should ensure that the hospital is aware of the policies and procedures of the child welfare organization and should help the child welfare organization maintain effective communication with the hospital, so that the hospital may appropriately use the organization's resources.

Provision by the child welfare organization for appropriate care of newborn children benefits the child and enhances cooperation between the hospital and organization. A hospital nursery is not a suitable facility for the care of a healthy child beyond the newborn period.

5.20 Payment for medical and hospital care

The child welfare organization should help the prospective or young parents find the medical and hospital care they need, and ensure that adequate care is provided regardless of the young parents' ability to meet the costs.

No adolescent or child should be denied the receipt of necessary medical or hospital care because of an inability to pay.

Several public programs provide care for free, or at cost, when it is needed for pregnant adolescents or young mothers and children who are vulnerable to health problems. Public or privately funded health insurance may also supplement the resources of the pregnant adolescent or young parents and their families.

5.21 Responsibility of the hospital administration

The hospital providing services to pregnant adolescents and/or young parents and their children should have defined policies regarding this population and should have specified procedures in place for reaching and informing them about the services that are available.

A policy statement, accepted by the heads of the department concerned, should be prepared and distributed to medical and paramedical staffs (i.e., nursery staff, dietitians). The policy statement should address:

- services for the pregnant adolescent who may need family foster care or adoption services for her child;

- services for the pregnant adolescent who plans on raising the child; and
- the relationship of the hospital to the child welfare organization serving pregnant adolescents (1) when the hospital has a social services department, and (2) when it does not.

5.22 Referral to social services

When the pregnant adolescent first comes to the hospital or clinic to confirm her pregnancy, she should be offered the help of a hospital social worker. If the hospital does not provide social work services, or if the pregnant adolescent prefers to obtain services from another social service provider, the hospital should refer the adolescent to any community resource that can provide the required social services.

Hospital and clinic staffs should be alert to the possibility that a pregnant adolescent will need social support services.

Even if the adolescent is not known to the hospital or social service agency until the delivery of her child, a determination of the need for social services should still be made.

5.23 Independent adoption

The child welfare organization has an ongoing responsibility to assure that hospital staff members who are in contact with pregnant adolescents are well informed about desirable adoption practices, including constructive terminology, and are familiar with relevant laws and procedures and able to interpret them. The child welfare organization should strongly discourage the hospital staff and attending physicians from any involvement in plans for independent adoption.

Where independent placement by the mother is legally sanctioned, such safeguards as the law provides should prevail (i.e., properly executed discharge forms giving mother's consent for release of custody to the designated person).

5.24 Medical report

The child welfare organization should seek permission from the hospital or physician to obtain a prompt report of the birth

history, the medical history, and findings on both the mother and the child.

When possible, the child welfare organization should obtain a medical history of the father.

Detailed medical records are necessary for fostering sound health practices for the new mother and for planning suitably and promptly for the child's care.

Arrangements for obtaining written permission from the mother for the hospital to furnish a medical report should be worked out between the hospital and the child welfare organization. The type of material available for a report and the need for the written request from the child welfare organization will depend on whether the hospital has a social service department and whether there has been a cooperative working relationship while the mother was under care.

5.25 Responsibility of the hospital social worker

If a child welfare organization is involved with the pregnant adolescent or young parent, the hospital social worker should assure that the hospital services required are appropriately provided in accordance with the total client service plan. If no child welfare organization is involved with the pregnant adolescent or young parent, the hospital social worker should assure that hospital services are appropriately provided and that referral to a child welfare agency is made.

The hospital social worker who is the first person to have contact with the pregnant adolescent should:

- make clear to the client that support services are available;
- evaluate the client's needs;
- select appropriate services based on the client's needs as revealed in the evaluation and refer the client to those services (i.e., housing, employment, adoption service, counseling, shelter care, financial assistance, education); and
- prepare for the most effective use of the required services at the point of discharge.

The hospital social worker should interpret the special service needs of the pregnant adolescent to the medical staff.

The hospital social worker should arrange appropriate referrals within the hospital and in the community, and keep these service resources advised of the medical recommendations and potential emergencies that may arise during pregnancy, delivery, and postpartum care, as well as any changes in the discharge plan. Where indicated, the hospital social worker should interpret the hospital's policies and services to the child welfare organization and relevant community organizations.

Allied Health Services

5.26 Responsibility of community health agencies

Community health organizations such as maternal and infant care programs, family planning centers, visiting nurses, well-baby clinics, school health services, or public health departments should take responsibility for identifying pregnant adolescents, young parents, and children who may be in need of help; for referring those individuals to child welfare agencies where indicated; and for ensuring that the parents and their child receive any necessary follow-up health services.

Public health organizations should reach out to mothers who may not come voluntarily to a child welfare organization, particularly those who are drug dependent, have HIV/AIDS or venereal disease, are alcoholics, or are mentally retarded.

The high rate of prematurity and maternal mortality among pregnant adolescents constitutes a continuing public health problem that must be recognized and appropriately serviced.

5.27 Family planning services

Family planning services should be made available to all sexually active adolescents and to their partners, regardless of age.

Family planning services for sexually active and pregnant adolescents, as well as young parents, should strive to prevent pregnancies by educating adolescents about all methods of preventing pregnancy, as well as anatomy, physiology, and other aspects of their sexuality; by providing counseling; and by providing contraceptive methods.

Education about family planning and human sexuality should cover a range of topics, including the fertility cycle, risks of pregnancy, types of contraception and possible side effects, anatomy and physiology, emergency contraceptive services, sexually transmitted diseases, dating and relationships, expectations about family size, and the costs of raising children. Sessions on these topics should ideally occur at regular intervals for adolescents, including those who are sexually active, those who are already pregnant, and those who are young parents.

Of particular importance during social work counseling sessions must be the emphasis on family planning and pregnancy prevention. Social workers should inquire frequently about the client's need for a contraceptive method, appropriate use of the current method, and impediments to use, such as money for transportation. Counseling should also cover the potential impact (financial, physical, and emotional) of a pregnancy in the near future, contingency planning should the current contraceptive method be unavailable or not used, and routine behaviors for employing contraceptives effectively. The client must be seen as responsible for his or her own sexual behavior, and appropriate support given toward achieving this end.

Adolescent clients should not be coerced into using family planning methods. Neither should the provision of other services, such as public assistance or job training, be tied to the use of contraceptives.

The initial provision of family planning methods and education must be followed up routinely with appointments and classes to ensure that the adolescent continues to use contraception appropriately. Reminder telephone calls and letters to the client may be helpful, within the bounds of confidentiality.

Focusing on young men as well as women is critical to the success of family planning services. Young men often influence women's reproductive attitudes and determine whether the use of family planning methods is acceptable and desirable. Clinic providers must ensure that men feel welcome and comfortable attending programs.

5.28 Parental notification and consent to contraceptive use

Parental notification or consent should not be required for the adolescent to obtain family planning services, specifically contraceptives.

Although parental involvement in a minor's use of such services is desirable, adolescents, whether already parents or not, have the right to control their own fertility. Child welfare organizations should make clear their policies regarding parental notification before providing services.

5.29 Mental health care services

A generally accepted, standardized diagnostic mental health assessment should be completed within 30 days of placement by a qualified mental health care practitioner. It should be considered an integral component of the health assessment.

The examination should be used to identify problems. This requires a mental health history, including reports from past and present mental health care providers, teachers, and caregivers. All records should be compiled and reviewed.

The use of age-appropriate and culturally relevant screening tools is necessary to detect any abnormalities of cognitive or emotional functioning.

The comprehensive mental health assessment should include documented observations of the caseworker in relation to the mental health status of the adolescent, reports secured from health care providers regarding past or current treatment recommendations, and locally sanctioned instruments for measuring behavioral and emotional well-being. Such measures should address dimensions of behavior, development, physical and neurological status, cognitive and educational status, and observations by the clinician.

Notes

1. American College of Pediatricians and American College of Obstetricians and Gynecologists. (1997). *Guidelines for Perinatal Care* (4th ed.). Washington, DC: Author.

2. American College of Pediatricians and American College of Obstetricians and Gynecologists 1997.
3. Fiscella, K. (1995). Does prenatal care improve birth outcomes? A critical review. *Obstetrics and Gynecology, 85*, 468–479.
4. U.S. Public Health Service. (1989). *Crying for our future. The content of prenatal care.* Washington, DC: U.S. Department of Health and Human Services.
5. Fiscella 1995.
6. U.S. Department of Health and Human Services, Public Health Service. (1992). *Healthy people 2000—National health promotion and disease prevention objectives.* Washington, DC: Author.
7. American Academy of Pediatrics. (1997). *Guidelines for health supervision.* Elk Grove Village, IL: Author.

6

Residential Services*

Although an increasing number of pregnant adolescents and young mothers are remaining in the homes of their parents or other relatives, and the demand for out-of-home care services such as maternity homes has declined, residential care during pregnancy and after delivery remains an essential element of the continuum of child welfare services required by pregnant adolescents and young parents.

Residential services provided to pregnant adolescents or young parents must be of high quality and sensitive to the needs of the pregnant adolescent, or young parents and their child. In particular, the out-of-home care placement should be able to provide services to adolescent mothers with special needs—those with mental, emotional, or physical handicaps; those who have been sexually abused; and those with substance abuse problems—because it is these youths who have the most difficulty in parenting their children effectively without the additional supports a residential living arrangement can provide.

Residential care programs should be seen as a series of services, events, and activities that can be divided into four phases. During the first phase, the adolescent acquires basic living skills through observation and instruction from members of the foster family. During the second phase, additional basic living skills are acquired through formalized instruction. During phase three, the youth practices the skills in real life situations and resides in some type of supervised independent living arrangement. In the last phase, aftercare, the youth lives independently, with-

* See CWLA *Standards of Excellence for Family Foster Care*, CWLA *Standards of Excellence for Residential Group Care Services*, and CWLA *Standards for Independent Living Services*.

out adult supervision, although the agency continues to provide services, including the recruitment and assignment of a mentor for the youth and regular monitoring of the service plan.

Goals for Residential Services

The goals of residential service during pregnancy are to provide safe shelter, adequate nutrition, and appropriate supervision for a pregnant adolescent who cannot remain in her own home or that of a relative; and to offer—either directly, through purchase of service, or through referral—a program of services to meet the multiple needs of a pregnant adolescent, including case management and counseling, advocacy, prenatal care, exercise, nutrition, continued education or employment, and preparation for labor, delivery, parenthood, or adoption (depending on the client's decision regarding the pregnancy's resolution).

The goals of residential services for young parents and their children are to provide adequate shelter and nutrition when such an environment cannot be provided by the young parents' families or obtained by the young parents; to offer a program of services for the young parents to enhance their future economic self-sufficiency, emotional stability, and parenting skills; and to insure quality care and stimulation for the infant or child of the young parents. Residential services should offer adolescent mothers nurturing and support, structure and discipline, and socialization. All are essential to enable young women and their children to move toward self-sufficiency.

Selection of a Living Arrangement

6.1 Remaining with own family or relatives

The social worker should help the pregnant adolescent to remain with her own family or relatives whenever possible, providing such a plan contributes to her well-being and, later, to the well-being of her child.

Planning with the adolescent should begin with an assessment of the strengths of the family members, including their health status and educational attainment.

Planning for the pregnant or parenting teen to remain with her own family or relatives is especially suitable when the family is in accord with the adolescent's plan, is willing and able to plan with her, and accepts and supports her during the pregnancy and after the birth of the child.

The plan for the adolescent should include pregnancy options counseling (adoption, abortion, parenthood); prenatal and postpartum health care services; income support; programs that improve the social, emotional, and cognitive development of the children of teenage mothers; and programs that enhance the life options of the adolescent mothers and fathers. Every effort should be made to involve the father of the baby and if appropriate, his family, in the development of the service plan.

A review of the plan by the social worker with the pregnant adolescent and her family should occur every two months.

6.2 Maintaining own residence

Emancipated pregnant adolescents—those who have lived away from their families and have been self-supporting—should be helped during pregnancy and after the child's birth to continue to live independently and to maintain their own residences.

Adolescent mothers who reside on their own are often the most needy and lack the support networks that adolescent mothers who reside with their families have. Although the young mother and child living independently may have food, shelter, and medical care provided, the absence of other individuals, especially supportive adults, may have negative consequences for her and her child. The social worker should consider connecting the teen mother with a mentor who can provide guidance and model desirable social behavior.

Without adult support or supervision, or lacking child day care and adult encouragement, adolescent mothers may drop out of school.

The absence of parental supervision may make sexual activity easier, leading to subsequent childbearing.

The social worker, pregnant or parenting teen, and her family should participate in the development of a service plan.

The plan should include pregnancy options counseling; care management and counseling; prenatal and postpartum health care services; income support; programs that improve the social, emotional, and cognitive development of the children of teenage mothers; and programs that enhance the life options of teenage mothers and fathers.

A review of the plan with the pregnant adolescent and her family and if possible, the father, should occur every month.

6.3 Out-of-home care

Out-of-home care should be used when the pregnant adolescent or young parent cannot live with her family or relatives or by herself due to abuse, neglect, or other circumstances.

The out-of-home care placement should be selected in accordance with a social work service plan, based on careful assessment with the pregnant adolescent or young parent of her needs, and on the formulation of short-and long-term goals.

The advantage of each residential placement option should be carefully weighed to assure the selection of the one that will best further the client's well-being and the goals of the social work plan. The availability or agency use of only one kind of resource is not an acceptable basis for making residential living arrangements.

6.4 Continuum of out-of-home care services

To meet the residential service needs of pregnant adolescents and young parents who will not be residing with their family or relatives, or in their own residence, the service system should offer a continuum of out-of-home care alternatives, including family foster care, group living, and independent living.

Family Foster Care

6.5 Family foster care for the pregnant adolescent

When the pregnant adolescent cannot remain in her family's or relatives' home, or maintain her own residence, family foster care during pregnancy should be considered.

Out-of-home care living arrangements are particularly important when pregnancy is the result of incest or when abuse or neglect is apparent or suspected.

The family foster care placement should be selected carefully and should be based upon the pregnant adolescent's plan regarding pregnancy resolution.

When family foster care is the placement of choice, the foster family should be viewed as a member of the service delivery team and involved in counseling to facilitate the client's prenatal care, counseling appointments, the setting of personal objectives such as school continuation or employment, and the modeling of healthy and appropriate family lifestyles.

The pregnant adolescent's biological family should not be excluded from services. Attention must be directed toward the client's return to her own or her family home whenever possible.

6.6 Family foster care for the young mother and her child

When the parenting adolescent cannot remain in her family's or relatives' home, or maintain her own residence, her parenting ability is not in question, and a transfer or parental rights is not being considered, every effort should be made to place her and her child together in family foster care.

Separation at an early age may have long-lasting effects for both the mother and child and should be allowed only in emergency situations. If separation does take place, the mother and child should be reunited at the earliest possible date.

If the mother and her child are separated, a visiting contract, specifying a visiting schedule and developmentally related tasks for mother and child, should be created and adherence to it encouraged and supported.

Care should be taken in selecting foster caregivers for young mothers and their children to assure that such caregivers can support the young mother's parenting abilities, and that they will not undermine or compete with her or harbor unrealistic expectations.

The foster family should be willing to facilitate the young mother and her child's receipt of services, such as medical care, education, employment counseling, and financial assistance.

6.7 Study and supervision of the family foster home

The child welfare agency should assess and evaluate potential family foster homes prior to placement of the adolescent, and should provide ongoing supervision and consultation while the pregnant adolescent or young parent and child are placed in the home.

Foster parents must meet the licensing requirements of the community or state. Each family foster home must offer the young mother and child living conditions that meet acceptable standards of health and decency.

Although flexibility is possible in family foster care, certain policies that meet the needs of both family and client must be formulated and followed. Regulations regarding housekeeping chores and visitors in the home may be needed.

Experienced social work staff members should assess and supervise foster parents and should provide consultation on a regular basis.

6.8 Foster parent qualifications

The agency should select foster parents who can accept the pregnant adolescent or young mother and child, the father, and the adolescents' parents without overidentifying with the adolescent or the child, and who can work cooperatively with the agency in accordance with the social work plan.

The pregnant adolescent or young mother and child need a supportive atmosphere of acceptance and respect. The foster parents must be able to offer that support, acceptance, and respect to the adolescent and to convey those feelings to the general community.

The foster parents should have a firmly established and mature relationship and be able to handle emotional upsets and crises with consistency and without excessive stress. If

other children are present in the home, the foster parents should be able to discuss and answer questions raised by the presence of the pregnant adolescent or young mother in the home.

The foster parents should refrain from imposing their own ideas on the adolescent, and from influencing the provisions of the service plan she works out with the social worker. The foster parents must be able to accept the time limitations of the placement and to fulfill their role as outlined in the social work plan. They should, however, be recognized as part of the service delivery team and their input should be requested and considered. The foster parents should understand and agree that they are assuming responsibilities that may include the provision of supervision, the scheduling of and transportation to clinic visits, and the arrangement of recreational activities.

6.9 Foster parent training

The child welfare organization should provide the foster parents with specialized training regarding pregnant and parenting adolescents, as well as preservice and inservice training that covers the basic principles of foster parenting. The specialized training should cover, at a minimum, sex role identification, the child's sexual development as part of total development, sexuality values, sexual acting out, sexually abused and exploited children, the sexually active teen, and community resources.

Specialized training regarding the healthy sexual development of youths can assist foster parents in:

- examining the way in which family living leads to the normal healthy development of sexuality in children;
- discovering that the way in which a family behaves teaches children to behave appropriately as men or women and teaches them a set of attitudes and values;
- understanding the different sexual behaviors of children and learning ways of dealing with "problem behaviors"; and

- learning to work with sexually acting out and sexually abused youths who may question their feelings about their sexuality.

The foster parent should be knowledgeable about child and adolescent development, sexuality education and disease prevention; and the health needs of infants, children, and adolescents.

The foster parent should be aware of and able to identify health problems, and should be able to communicate about those problems to the adolescent mother, health professional, and social worker.

The foster parent should provide guidance to the mother on securing medical care for herself and her child. Working with the health care professional, the foster parent should assist the young parent in promoting healthy development for the child.

6.10 Payment for care

The child welfare organization should provide payment to family foster caregivers who care for a pregnant or parenting adolescent in the home in accordance with the organization's established procedures and rates.

The child welfare organization should fully subsidize the costs incurred by the foster parents for the care of the pregnant or parenting adolescent and her child.

If the adolescent mother and her child are in care together, arrangements should be made to cover them both.

Responsibility for payments and incidental costs rests with the child welfare organization. The pregnant adolescent or young mother who can contribute part or all of the cost of care should make payments to the agency and should not make any payment directly to the foster family.

Group Living Facilities

Group residence staff members are uniquely positioned to monitor a client's behavior and daily receipt of services.

This may be particularly advantageous for pregnant adolescents who are at high risk of prematurity or complications during delivery. The group residence staff must be attuned to any special needs of their clients such as developmental disabilities, emotional disturbance, or drug abuse, and must be sensitive to their capacity as staff members to influence the client's pregnancy course and future. The client's plan for pregnancy resolution must not affect the organization's decision to provide residential group living arrangements.

6.11 Group living residences for young mothers and their children

Group homes or institutional residences should be available to those pregnant adolescents who cannot live with their parents or relatives because of family conflict, lack of access to medical care, abuse, neglect, rape or incest, drug abuse, developmental disabilities, or emotional problems; to homeless youths; to youths who cannot manage to live independently; and to youths who do not want or cannot cope with family foster care and who may benefit from a structured living arrangement with peers in a situation similar to their own.

The group residence for young mothers and their children is particularly suitable for mothers with special needs—those who are potentially abusive or neglectful of their children or those with mental, emotional, or physical impairments who require specialized services.

Group residences can closely supervise the young mother and her child, and can make available on-site needed supportive services. Such programs should offer clients a wide array of services, including education, medical care, parenting education, transportation, child care, independent living skills, case management, counseling, and advocacy.

Young mothers living in group residences should be integrated into the life of the community as much as possible.

Residential programs for young mothers and their children should operate within a set of specific client goals, developed with the young mother. An orientation to the facility should occur within 24 hours of the young mother's arrival.

The length of stay in the program should be limited to facilitate the client's self-sufficiency, or her return to the home of a parent or other relative.

6.12 Characteristics of group living arrangements

Residential services for pregnant and parenting adolescents and their children should offer a full spectrum of programs to address the most basic of human needs—housing, child care, education, health care, counseling, and nutrition. Services should be designed to offer clients the opportunity to preserve and maximize their life options by assisting them in developing the skills they require for economic independence, self-sufficiency, and long-term family stability.

Insofar as possible, group residential care should offer the pregnant adolescent or young mother:

- the security, guidance, and support she may need to prepare herself for the physical, social, and emotional responsibilities of pregnancy, childbirth, and motherhood;
- care and protection of the child, when appropriate;
- a program to meet her specialized emotional, physical, educational, vocational, and recreational needs;
- opportunities for personal growth through supervised group living experiences and creative programs; and
- treatment of emotional problems through planned use of the group living program's resources and services.

6.13 Policies and Procedures

The policies and procedures of the residential facility must carry forward the purpose of its services for pregnant adolescents and young parents. They should be carefully developed and subject to constant reevaluation in the light of changing needs.

6.14 Admission policy

The decision to place a pregnant or parenting adolescent in residential care should take into account whether the placement is

(1) the most appropriate, and (2) in the best interests of the client.

Homes under religious auspices or those set up to serve a particular group or special social problem should define their admission policies clearly. In general, policies should state that no applicant should be rejected because of race, color, legal residence, previous marital status or pregnancy, economic status, or ability to pay.

If the child welfare organization cannot provide the necessary and appropriate living arrangements, its policies should provide for referral to other community resources that can better meet the needs of the young parents.

It is difficult for the mother to enter a residence until she perceives that she needs help. Therefore, the organization's policies should not require her to be admitted at any specific stage of pregnancy, nor should her eligibility depend upon the plan she has for her child or her willingness to remain in the group residence for any specified period of time beyond that required for the achievement of the objectives in the social work plan or receipt of appropriate medical care.

The social worker in a group residence, in consultation with the administrator and supervisory staff, or both, should make the decision whether to accept an applicant for residential care on the basis of the needs of the applicant, the composition of the group currently in residence, and the nature of the service.

6.15 Intake

Prior to placement, the intake specialist should conduct an intake interview, obtain the adolescent's history, and assess the adolescent's level of maturity.

The history should include previous placements and reasons for leaving, according to both the youth and the caseworker.

The adolescent should be given an orientation to the facility that describe the organization's expectations, rules, and guidelines, as well as any individual contracts.

All youths entering residential care should be screened for health, mental health, and drug and alcohol problems. If a condition is present, the youth should be involved in or have completed a treatment program relating to the problem. Other community agencies that the youth is involved with should also be identified.

6.16 Client Contract

Before placement in a group living residence, a written contract between the agency providing the program and the youth participating in the program should be developed that outlines the specific responsibilities of the youth as well as the supervisory responsibilities of the agency and a description of the consequences if the youth fails to comply with the contract.

Agencies may want to include such things as the residence's rules for residents to perform chores, to attend school, keep scheduled appointments, respect the property of the agency and others, keep child in child care while in school, take responsibility for visitor's actions, etc.

Any changes to the contractual agreement should be negotiated and signed by both parties.

6.17 Client Record Standards

The records of the pregnant or parenting adolescent and her family should be maintained in a manner that ensures their privacy and confidentiality.

The contract should be signed by the client and the social worker.

The organization should provide to the adolescent and her family a written policy statement on the release of identifying information about the child, biological parents, and potential adoptive parents in instances where adoptive placement is made; such policies shall conform to state law.

6.18 Licensing of group living residences

All group living residences administered by child welfare agencies should be licensed or authorized to operate by an appro-

priate state or provincial agency and should meet all state or provincial licensing requirements for health and safety.

Jurisdiction and requirements for licensing of a residential facility depend on the scope of the activities of the home. In general, licensing will involve different state or provincial departments that regulate minimum standards of care. When the facility is subject to the jurisdiction of several state or provincial departments, each department should assume responsibility for licensing the facilities used for that particular service component.

The following considerations are determinants for licensing jurisdiction:

- If the group living facility admits female adolescents in the age group for which state or provincial law requires licensing as a child care facility, or if the facility cares for their infants, it should be licensed by the state or provincial department as a child welfare service.
- If the group living facility provides child day care, it should meet the licensing requirements for a child day care facility.
- If the group living facility provides family foster care or adoption services, it should be licensed as a child placement agency.
- If the group living facility provides medical treatment, nursing care, or hospital services, it should be subject to the licensing jurisdiction of the state or provincial department of health, as well as to review by the appropriate accrediting bodies in the practice of medicine and hospital administration.

6.19 Caseload standards

Staff workloads should be established that allow full service provision to each client in residential placement.

For infant day care services provided on site when the parents are absent, the staff ratio should be one day care worker for every four babies. For infant day care services provided on site while the adolescent mother is in attendance, the

staff ratio should be one day care worker for every three infants.

The ratio of professional service management staff to clients should not exceed one service manager to 17 clients. The ratio of paid and volunteer direct service staff to clients in the facility should not exceed 1 to 20 at anytime.

Treatment agencies should employ one full-time social worker for every 15 adolescents in placement.

6.20 Residential staff qualifications

The personnel providing service shall be appropriately qualified, licensed, or certified to carry out the organization's program of services.

These standards apply to all of the service provider's personnel, including volunteer and paid employees, professional and paraprofessional staff, and administrative and direct service staff.

All paid direct service staff should have as least a bachelor's degree in social work, psychology, counseling, or a related social service field.

All personnel providing clinical counseling services should be licensed or certified in accordance with state law governing clinical practice.

All personnel providing medical care should be certified or licensed in the applicable health care field.

All paraprofessional support staff should have a high school diploma or GED and be certified in the area in which they are working.

Before coming in direct contact with clients, volunteer direct service staff who are to work 10 or more hours per week should receive training in the particular service they will be providing.

6.21 Residential staff training

Agency staff should be provided with adequate and appropriate ongoing training, including an orientation to the program

prior to employment and, within 90 days of employment and annually therefore, training in CPR for infants and children, staff boundaries, appropriate relationships with youths, nonjudgmental attitudes, parenting, child and adolescent development, the effects of sexual abuse, confidentiality, evacuation routes and procedures, and emergency procedures in the event of fire or other disaster.

Within 90 days of employment, all paid and volunteer staff should complete a standard course in emergency first aid, and in CPR for children and adults.

Supervisory and direct service staff should receive at least 40 hours of training annually.

6.22 Case management

The child welfare organization should provide case management services for the pregnant or parenting adolescent in residential care.

In many organizations, social work services provide case management services for clients. Case management services often are essential for marshaling, in behalf of an individual or family, the diverse health, social service, child day care, educational, employment, and financial assistance resources that may be necessary for adolescent parents and their child.

Case managers should coordinate or provide:

- a full assessment of an individual's or family strengths and needs, including the use of specialized diagnostic services as needed;
- the development of a plan of services;
- the implementation of the plan, by arranging for the delivery of a variety of public and private services;
- follow-up and assessment of the effectiveness of services, with a change in the service plan as appropriate;
- advocacy in behalf of the individual or family to ensure that services or benefits are received; and
- educational activities while the client is in a group residence.

6.23 Social work in a group residence

Ongoing social work services should be provided as an integral part of the program for the pregnant adolescent or young mother for as long as necessary.

The services may be offered by the social worker in the group setting itself, a social worker in the child welfare organization of which the group setting is a part, or a social worker of a child welfare organization from which the care was purchased.

The social worker in the group residence is responsible for helping the client make the best use of residential care.

The social worker should help the pregnant adolescent or young mother to adjust to and make use of the living experience in the group residence; should coordinate services within and outside the home for each client in accordance with the social work plan; and should interpret the use of the home to other staff members of the agency and to other social agencies and community resources.

Individualized services should be complemented by group activities and group discussions.

Some of the problems that all pregnant adolescents or young mothers share can be discussed in informal group meetings, at which attendance is voluntary. Joint discussion of mutual problems can give the helping process an added dimension. The social worker who leads discussion groups should have a thorough knowledge of group practice methods and be familiar with social work concepts concerning the problems and care of pregnant adolescents and young mothers.

6.24 Educational services for adolescents in residential facilities

Educational activities should be planned in accordance with the needs of the individual pregnant adolescent or young parent and the social work plan for her.

Formal academic instruction should be available for the school-age pupil during pregnancy and after the birth of

the child, unless contraindicated for medical reasons. The young father should be helped in the same way.

Education programs should provide for remedial education and tutoring, as many adolescent mothers are behind grade level. Many teen parents feel more comfortable in General Equivalency Diploma (GED) programs and may decide to matriculate in those programs; some programs may offer the GED on site. Arrangements should be made through the local board of education for accredited instruction to ensure that credit will be given for work completed. Safeguards may be necessary to assure that information about the pupil is kept confidential if credits are to be transferred.

Vocational skill training should be directed at the development of appropriate employment skills in the adolescent. The link to the world of work must be emphasized since many teen mothers grow up in homes where family members are underemployed. Job readiness skills such as interviewing, appropriate work attire, and socialization (timeliness, working with coworkers) should be included. Linking young mothers to mentors on the job who can give advice and guidance and model appropriate behavior is particularly helpful.

Family life education, including abstinence and contraception, should be available to all residents. Instruction should also be provided on the care of infants, including infant and toddler development; appropriate discipline; immunization schedules; and safety in the home for infants and children.

6.25 Medical service for adolescents in residential facilities

Medical and hospital care should be obtained through arrangement with community medical and hospital facilities, or as a part of a group residence program, provided that in quality such care corresponds to acceptable medical care available through other community resources. All pregnant clients should receive regular and continuous prenatal care.

Within three months of program entry, the health of at least 95% of the clients in the residential program should be

improved or at least maintained. At least 80% of the pregnant clients should have no delivery complications.

Prior to delivery, the client should have a plan for herself and her child, including family planning and health care services for herself and her child.

Arrangements for medical services should assure continuity of health and medical care and social work service. Before leaving the residence, the client should know the health care professionals that she and her child will use as well as how to make medical appointments for herself and her child.

6.26 Payment for care

The pregnant adolescent or young mother who uses residential care should pay the agency, according to her ability, for the expenses of her living arrangements and medical care, expenses for her child, and the cost of additional services rendered.

Financial arrangements should be made that will assure stability of placement for the pregnant adolescent or young mother and child. The costs may include higher rates after the child is born.

Ability to pay should be determined on the basis of current circumstances. Members of the young mother's family and/or the young father, should, if appropriate and possible, assist the young mother in meeting the costs of care.

6.27 CWLA standards and Council on Accreditation provisions

All family foster care and group or institutional residential programs used by the child welfare organization should meet the relevant Child Welfare League of America standards, as well as the provisions of the Council on Accreditation of Services for Families and Children, Inc.

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